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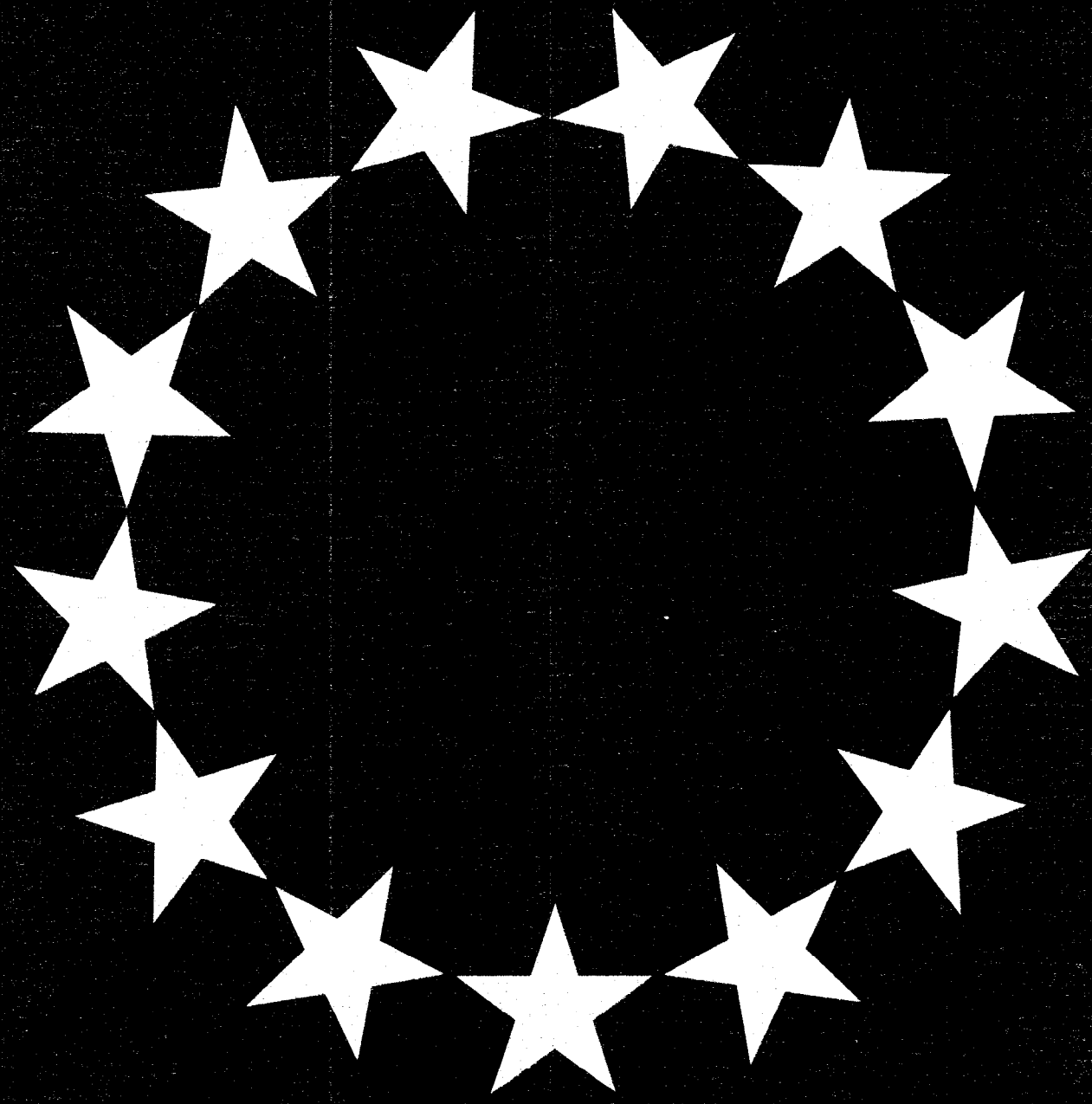
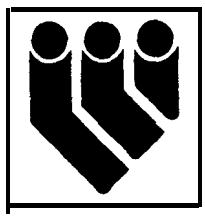
NATIONAL GOVERNORS' ASSOCIATION

State Policy Reports

Health Policy Studies





STATE INITIATIVES TO IMPROVE RURAL HEALTH CARE

NATIONAL GOVERNORS ASSOCIATION

State Policy Reports

Health Policy Studies

by Amanda H. McCloskey and John Luehrs

Health Policy Studies
Center for Policy Research
National Governors' Association

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The National Governors' Association, founded in 1908 as the National Governors' Conference, is the instrument through which the nation's Governors collectively influence the development and implementation of national policy and apply creative leadership to state issues. The association's members are the Governors of the fifty states, the commonwealths of the Northern Mariana Islands and Puerto Rico, and the territories of American Samoa, Guam, and the Virgin Islands. The association has seven standing committees on major issues: Agriculture and Rural Development; Economic Development and Technological Innovation; Energy and Environment; Human Resources; International Trade and Foreign Relations; Justice and Public Safety; and Transportation, Commerce, and Communications. Subcommittees and task forces that focus on principal concerns of the Governors operate within this framework.

The association works **closely** with the administration and Congress on state-federal policy issues through its offices in the Hall of the States in Washington, D.C. The association serves as a vehicle for sharing knowledge of innovative programs among the states and provides technical assistance and consultant services to Governors on a wide range of management and policy issues.

The Center for Policy Research is the research and development arm of NGA. The center is a vehicle for sharing knowledge about innovative state activities, exploring the impact of federal initiatives on state government, and providing technical assistance to states. The center works in a number of **policy** fields, including agriculture, economic development, education, environment, health, social services, training and employment, trade, and transportation.

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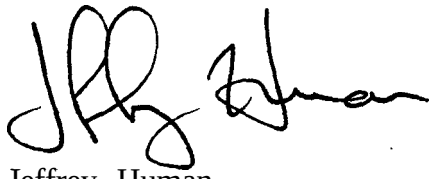
Foreword

We are pleased to present this report, *State Initiatives to Improve Rural Health Care,* a joint effort between the federal Office of Rural Health Policy and the National Governors' Association. Both organizations are committed to seeking solutions to health care problems in rural America and see this project as a significant step toward reaching that goal.

Rural health issues have attracted significant interest during the past several years. Governors have become acutely aware of failing rural hospitals and the shortage of health personnel in rural communities. At the federal level, a broad range of legislative and program initiatives have been implemented, including the creation of a federal Office of Rural Health Policy. Many states also have moved forward with their own programs, including the establishment of offices to serve as the focal point for rural health.

This publication describes a broad range of ongoing state programs and policies that are designed to improve access to health care in rural communities. It presentsthe results of a state survey and includes profiles of state rural health task forces and commissions, state offices of rural health, and state rural health programs. By identifying approaches states have used to address the common problems in rural health care delivery, this document provides an information base to guide future rural health initiatives.



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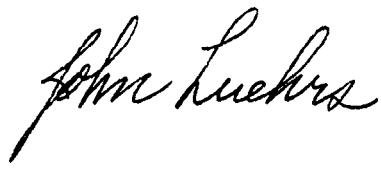

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1. Introduction

Barriers to Health Care in Rural America

Access to health care continues to pose a problem for the 56.9 million Americans who reside in nonmetropolitan areas. Difficulties in attracting providers to rural locations and the increasing number of rural hospital closures are major obstacles. This lack of a health infrastructure reduces rural residents' access to health care. Exacerbating an already bad situation is the large geographical distances between communities and services.

While urban areas have 1.5 physicians per 1,000 residents, physicians clearly are in short supply in rural areas with only .67 physicians per 1,000 residents. Compounding the problem is the retirement within the next five years of one-quarter of the physicians presently practicing in rural communities.

To a large extent, the access problem can be attributed to the inability of rural communities to attract and retain physicians. Young physicians are recruited straight out of residency, move to rural areas, and quickly find that the low pay combined with their large student loan obligations make life in a rural community unattractive. In addition to financial worries, these physicians often are discouraged by the lack of modern equipment to which they have been accustomed in America's teaching hospitals. Moreover, they are likely to be the only physician within a thirty-mile radius. The result is few colleagues with whom they can confer and little or no personal time for family and vacations because no one is qualified to cover for them in their absence.

The closure of hundreds of rural health care facilities is contributing to the access problem. Between 1973 and 1988, more than 700 rural hospitals closed; in 1988 it was estimated that as many as 600 more rural hospitals will close during the next few years. The requirements on hospitals to remain open and fully staffed at all times, even without any patients, place great financial strain on these facilities. Although they may be the only health care facility within thirty miles, the low occupancy rates commonly experienced by rural hospitals, makes it difficult for them to financially justify keeping their doors open. As a result, many rural facilities have closed.

Also contributing to the access problem is the inherent isolation of rural communities. The great distances between residents and health care facilities makes accessing health care difficult. It is not uncommon for rural residents to have to travel at least thirty miles to see a doctor. This presents further complications for women

seeking prenatal care. Reflecting a nationwide trend related to liability concerns, many physicians in rural areas have ceased providing obstetrical care, forcing women from rural communities to travel still further to receive prenatal care.

Rural areas also confront barriers relative to the quality of health care. Newer, more advanced equipment often is too expensive for a physician in his or her own rural practice to purchase. Many rural hospitals do not have the capital to obtain such equipment or cannot demonstrate sufficient financial stability to qualify for a loan to purchase the equipment. As a result, rural residents in need of special care must travel to the equipment, which usually is located at facilities in more urban areas of the state.

The issue of quality health care is not limited to care available through a physician or hospital. The lack of emergency medical care also is problematic due to an insufficient number of certified emergency medical services providers. Interested and qualified rural community residents generally cannot access the required instruction and certification processes. Provider courses usually are not offered in rural communities, so interested residents must take time away from their full-time job and assume the costs of traveling to a location where they can be trained and certified.

Access to quality health care services is further complicated for special needs populations such as the elderly or persons with Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). For the elderly rural resident these access and quality issues present a new set of barriers. Communities with high percentages of elderly typically experience greater demands for health care services than do those with younger populations. In addition to requiring more health care services, the elderly in any area often rely on family and friends to provide transportation to and from doctor visits. In more urban environments, mass transportation, taxi services, and special senior citizen shuttles typically are available alternative modes of transportation. In rural communities this is not the case, The elderly must rely strictly on friends and family when they are unable to drive and are in need are transportation.

The increasing prevalence of HIV and AIDS in rural areas is causing yet another set of service and financing demands to be made on already strained rural health care systems. Persons with HIV/AIDS face a number of barriers to receiving adequate care in rural areas, including difficulty in identifying primary care practitioners who are trained and willing to treat HIV disease; lack of adequate insurance coverage to pay for costly care; limited access to new drugs and experimental protocols, and sparse referral networks to appropriate social services and medical specialists. The shortage of health professionals, the lack of supportive care services, and the long traveling distance to specialty centers also are problematic.

In recent years the issue of health care in rural America has gained national attention with the result that new programs have been established to reduce gaps in services, improve quality, and facilitate access. Most of the initiatives have been spearheaded by states, though some rely on the direction and backing of the federal government. In addition, a number of private foundations and community-based organizations are looking for ways to address the health care problems in rural areas.

NGA Survey on Rural Health Initiatives

In early 1990, the National Governors' Association (NGA) surveyed rural health experts in each state to identify programs that are designed to improve health care in rural areas. More than 100 programs in more than thirty states are focusing on:

- Maintaining existing health care facilities;
- Recruiting and retaining health care professionals;
- Increasing access to obstetrical care;
- Improving the availability of emergency medical services;
- Increasing services for the medically indigent;
- Establishing substance abuse treatment programs;
- Enhancing activity coordination;
- Providing financial and technical assistance; and
- Improving environmental and occupational health and safety awareness.

The programs identified through the NGA survey are included in the last chapter, "Compendium of State Rural Health Initiatives." The compendium only describes state-funded programs that primarily, if not exclusively, serve residents of rural areas. Rural health initiatives that are not funded by state government are not included in the compendium.

The NGA survey also collected information on state-level task forces and commissions on rural health that have been operating within the last three years and on state offices of rural health. Twelve states submitted reports on the findings and recommendations of their task force or commission. Highlights of these reports appear in chapter two of this publication. The historical activities of twenty-three state offices of rural health are summarized in chapter three of this report.

The Federal Response

The federal government has a long history of involvement in rural health care. Both the legislative and executive branches have undertaken a number of initiatives to increase the quality and access of health care in rural America.

Legislative Branch. In recent years Congress has enacted several pieces of legislation designed to increase the effectiveness and availability of health care in rural areas. The federal efforts range from establishing a federal response network, through creating the Office of Rural Health and the National Advisory Committee on Rural Health, to increasing reimbursement to rural facilities and providers.

One of the more notable pieces of recent legislation is the Essential Access Community Hospital Program, which was authorized under the Omnibus Reconciliation Act of 1989. It creates two new categories of rural health care facility: Essential Access Community Hospitals (EACHs) and Rural Primary Care Hospitals (RPCHs). The legislation requires the U.S. Department of Health and Human Services to provide grants to up to seven states for the development of EACHs and

RPCHs. Benefiting from less stringent staffing and service requirements, EACHs and RPCHs ensure regional accessibility and continuity of emergency, primary acute, and long-term care services. EACHs serve as rural hospitals and provide emergency and medical back-up services to designated RPCHs. EACHs must be thirty-five miles from another hospital, EACH, or referral center and have at least seventy-five beds. RPCHs primarily provide emergency care but can offer minimal inpatient care for up to seventy-two hours.

The National Health Service Corps (NHSC) was established in 1970 to provide health personnel to designated Health Manpower Shortage Areas. The primary tool of the corps is its scholarship program. Physicians must serve communities for a period equal to each year of tuition support, with a minimum two-year obligation. Until 1980 these physicians were guaranteed a federal salaried position. However, subsequent reductions in NHSC funding reduced the number of federal salaried positions, effectively eliminating the guarantee. In 1989, for example, $65 million was authorized but only $38 million appropriated. The last few years have seen a decrease in the number of corps assignees in rural areas from nearly 1,850 to about 1,450.

Authorized under the Omnibus Reconciliation Act of 1987, the Rural Health Transition Grant Program provides annual grants of up to $50,000 to assist small rural hospitals (less than 100 beds) and hospital consortiums. It is designed to minimize the effects on hospital services of closures in rural communities. In its first year the program provided financial assistance to 184 hospitals and hospital consortiums; the number of grants increased to 211 in 1990.

The Congress recently passed legislation to make federal matching funds available to state offices of rural health and to reauthorize and increase funding for the National Health Service Corps. New legislation continues to be introduced to increase reimbursement to rural health care facilities and rural providers.

Ongoing congressional interest in rural health issues is assured through the Senate Rural Health Caucus on Rural Health and the House Rural Health Care Coalition. The Senate Rural Health Caucus is a bipartisan coalition of Senators who share an interest in rural health issues and legislation. It was founded in 1985 by Democrat Quentin N. Burdick and Republican Mark Andrews, both of North Dakota. A growing interest in rural health issues clearly is evident in the expansion of the caucus from its initial membership of about thirty senators to its present membership of seventy-four.

While the caucus does not introduce its own legislation, it serves as a unified voice for the Senate for quality rural health care, promoting rural health issues before the administration and supporting legislation beneficial to rural America. Some of the initiatives supported by the caucus include raising Medicare hospital reimbursements by providing an increased update factor for rural hospitals and requiring the Secretary of Health and Human Services to develop a legislative proposal to phase out separate urban/rural payments by 1995. The caucus also was instrumental in delaying the implementation of the department's proposed Health Manpower Shortage Area regulations that would have eliminated 670 of the 1,955 designated areas and public health support programs.

The House Rural Health Care Coalition was established in 1987 with about forty members. Similar to its counterpart in the Senate, this bipartisan coalition has grown rapidly to its present membership of 145. The coalition has been successful in passing legislation to increase payments to rural health care facilities and to create the Office of Rural Health Policy and the National Rural Health Advisory Committee. The group's most recent package urged the elimination of the urban/rural hospital differential payment by fiscal 1991 and the enactment of the National Health Service Corps Revitalization Act of 1990 to reauthorize and improve the National Health Service Corps.

Executive Branch. The Office of Rural Health Policy and the National Rural Health Advisory Committee were established in 1987. The Office of Rural Health Policy (ORHP) is housed within the Health Resources and Services Administration of the U.S. Department of Health and Human Services (DHHS). The office's role is to work within the department and with other federal agencies, states, national associations, foundations, and private sector organizations to seek solutions to health care problems in rural communities.

ORPH staff also serve as staff to the National Advisory Committee on Rural Health. The purpose of the eighteen-member advisory committee is to advise the Health and Human Services Secretary on how to address the issues and unique problems related to providing and financing health care services in rural areas,

The State Response

Access to quality health care is essential to a rural community's economic development. If it cannot ensure the availability of health care to its residents, a rural community will be unable to attract new industry. Without new industry further economic growth is more difficult, if not impossible. Therefore, despite recent fiscal difficulties, states are devoting considerable attention to improving access to quality health care in rural areas. Indeed, many states are identifying rural health care as a priority issue.

A milestone in state rural health initiatives was the formation of the first office of rural health by the North Carolina Legislature in 1973, some fourteen years before the federal office was established. By 1990, twenty-two states had developed twenty-three offices of rural health. In addition, twelve states have established a task force or commission within the last years. These developments reflect the increasing state interest in rural health.

According to the NGA survey, thirty-four states have enacted at least one program to improve access and quality of health care for their rural residents. The most significant problems continue to be maintaining existing health care facilities and recruiting and retaining health care providers. Thus, common components of state rural health initiatives include educational assistance programs; grants and loans to subsidize overhead and other start-up costs; and programs to assist with the payment of malpractice premiums. In addition to direct financial and technical assistance, a few states have established grant programs, similar to the federal Rural Health Transition Grant Program, designed to assist rural hospitals.

A popular option used by states to assist failing rural hospitals is the Medical Assistance Facility (MAF). MAF is a new licensing category that gives rural hospitals greater flexibility in service provision and staffing. MAFs are allowed to close their doors if they have no patients, though they must have a registered nurse on call twenty-four hours a day. This enables hospitals to utilize only essential personnel when they have no patients. Reducing the staffing and service requirements of rural hospitals allows them to save money that once paid salaries in idle facilities. Several states, including California, Florida, and Montana, are using this approach.

While maintaining existing health care facilities and recruiting providers remain at the top of the list, many other common problems do exist. These include insufficient emergency medical services (EMS) providers, inadequate occupational and environmental health and safety programs, and difficulty in accessing prenatal care.

States have developed a variety of programs to address these problems. To increase the number of EMS providers several states have established mobile training units that travel to rural areas to provide certified training opportunities to interested community members. To reduce the incidence of farm-related injuries, states have begun providing educational information on farm safety, including on-site farm safety inspection. To increase access to prenatal care, several states have offered insurance and tax incentives to rural physicians who provide obstetrical care in communities where no obstetrical care is available.

Clearly, individual Governors have recognized the growing problems of health care delivery in rural areas and have taken action. In addition, increased interest in rural health care is apparent in the Governors' collective actions. The Governors on the National Governors' Association Committee on Agriculture and Rural Development have made rural health a priority issue on their policy agenda for the past two years.

Based on the recommendations of the Committee on Agriculture and Rural Development, the Governors adopted a rural health policy statement in February 1989. The policy recognizes the relatively lower health status of various rural populations, including the elderly and infants residing in low-income families. The statement also recognizes the higher rate of occupational injury occurring among rural populations. The policy advocates a system that allows for identification of health needs at the local level. It calls for integration of health concerns into rural economic development plans. Specifically, the policy looks to an integrated public health care system with flexible medical facility planning and flexible licensure, certification, and conditions for participation. The Governors on the committee consistently identify access to quality health care in rural areas as one of the most pressing issues on their state agendas.

Conclusion

The last few years have seen a marked increase in attention to the problem of accessing quality health care in rural areas. The growing recognition of rural health as a significant domestic policy issue is evident in both the state and federal response. Although several rural health initiatives have been implemented to improve quality

and access, they clearly are not enough. With one-quarter of the U.S. population residing in rural areas, the health care needs of rural populations have important implications for the economic and social well-being of the nation. The states and the federal government need to consider targeting additional efforts to rural communities to address the substantial problems that remain in the delivery of health care in rural America.

2. State Commissions and Task Forces on Rural Health

Introduction

State concern about rural health issues is reflected in the fact that twelve states have established thirteen commissions or task forces to examine their policies and programs for promoting rural health. Of the thirteen, four were established by Governors, six were established by state legislatures, one was established by a Lieutenant Governor, and two were established by private concerns. State commissions and task forces on rural health typically operate for about one year, though their charters range from five months to two years.

Purpose and Membership

Responses to the NGA survey reveal striking similarities in the way states are using these task forces and commissions and in how they have organized them to carry out their mission. State commissions and task forces on rural health generally have been charged with assessing health care delivery in rural areas and recommending solutions to the problems they identify. In some cases, the groups initially were asked to address specific issues, but their charge subsequently was expanded to focus on broader concerns. For example, in Texas, the commission first focused on the impact of the numerous hospital closures on rural communities. Later, it was asked to address the potential impact the hospital closures might have on Texas's rural health care system. In other cases, the more limited focus was sustained throughout the life of the task force or commission, for example, to make recommendations for improving access to obstetrical services in rural Washington.

Reflecting the diversity of interests and disciplines converging on the issue of rural health care, all the state commissions and task forces included representatives from both the public and private sectors and from numerous professions. Public members included Governors, state legislators, state agency representatives, and local elected officials. The private sector members represented hospitals and providers, professional societies, and a variety of health care-related industries. A few of the commissions and task forces established' technical advisory panels composed of experts in the subjects under study. Based on the NGA survey, state commissions and task forces ranged in size from nine to forty members, averaging about twenty members.

Findings

The reports of state commissions and task forces document common problems in rural health care, and the findings are remarkably comparable across states. In several states numerous counties are without a hospital or a practicing physician. Where such facilities or practitioners are available, some will not treat the indigent, making access to health care even more difficult for low-income rural residents. Moreover, several states found substantial differences in rural and urban hospital Medicare reimbursement rates that are likely to affect the ability of rural areas to attract health care professionals. In addition to the lack of health care providers, the emergency medical service provider population is declining in many states. While the effects these findings have on individual communities vary from state to state, it is clear that the underlying problems are very similar and include:

A large number of hospital closings and great distances between the location of health care facilities and rural residents.

- Texas has experienced sixty-five hospital closures, representing 20 percent of all U.S. hospital closures.
- Alabama has experienced eleven hospital closures.
- In Washington the average occupancy rate for rural hospitals is 33.2 percent.
- In 1989 the average occupancy rate for seventy-two small rural hospitals in Alabama was 35 percent; some hospitals have a rate as low as 7.6 percent.
- Thirty-three hospitals in Minnesota have been identified as being in a "precarious" financial condition.
- About 19,000 Minnesotans in fourteen northern counties must travel more than thirty minutes to a hospital.

A shortage of health care personnel in rural areas, includingphysicians, registered nurses, and physician as&ants.

- ***In*** Texas fourteen counties do not have a physician. These counties cover an area larger than nine U.S. states and the District of Columbia.
- In Iowa 20 percent of the family practitioners are sixty years of age or older and more than 170 communities are actively recruiting physicians.
- In Alaska medical liability premiums more than doubled between 1985 and 1988.
- Nearly 60 percent of Alabama residents live outside urban centers, yet only 33 percent of physicians in the state practice in rural areas.

A shortage of obstetrical care providers.

- More than one-third of Alabama's counties do not have access to hospital obstetrical services.

- In Iowa sixteen counties do not have a hospital withobstetrical services for low-income women. These women must travel up to fifty miles to other county hospitals.
- Ninety-two of 254 counties in Texas do not have hospitals that provide obstetrical services, and 61 percent of the general and family practitioners have either curtailed or abandoned obstetrical care.
- In Alabama the number of obstetricians and family practitioners who deliver babies has declined by more than 50 percent, from more than 400 to less than 200.
- Alaska has the highest infant mortality rate for infants between the age of one month and one year.
- In rural Texas nine low-birthweight babies are born each day, with five rural infant deaths occurring every four days.
- In Washington family practitioners pay between $16,000 and $25,000 for $1 million to $7 million worth of insurance coverage. Obstetricians' malpractice premiums range from $39,000 to $63,000 for comparable coverage.

A lack of adequately trained emergency medical services personnel and trauma care personnel.

- Three-fourths of ambulance services in Iowa are volunteer.
- The emergency medical services population in Iowa has decreased by 40 percent since federal emergency services funding ceased in 1981.

Insufficient reimbursement for rural health facilities and providers.

- In Nebraska rural hospitals and providers receive, on average, 40 percent less than their counterparts in urban areas.
- In 1987 the average reimbursement under Medicaid for medical assistance to rural hospitals in Washington was about 60 percent of charges.
- In Washington the average reimbursement under Medicaid for physicians is well below 50 percent of charges.

Recommendations

The recommendations of the rural health commissions and task forces to address these identified shortcomings focused on revising state laws and regulations and establishing new programs. Some common solutions were proposed in the following areas: access to health care, recruitment and retention of health care professionals, emergency medical services, and reimbursement.

Access to Health Care. Several commissions and task forces sought to increase access to health care services by promoting the use of caregivers other than

physicians such as registered nurses, physician assistants, and nurse practitioners, while also making better use of volunteers to provide supportive services.

The Washington Rural Health Care Commission recommended easing restrictions on prescription authority in order to allow registered nurses to dispense medications when a pharmacy is not reasonably available or to distribute prepackaged controlled substances based on a physician's orders. The task force in Iowa recommended using volunteers to arrange and provide transportation. Volunteer drivers can be attracted by providing limited liability or offering other incentives such as a state tax credit.

Recruitment and Retention of Health Care Professionals. A number of recommendations were developed to enrich the professional lives of rural physicians by easing their financial burdens through loan forgiveness programs, making continuing education and training programs available, and reducing workload by increasing the use of allied health professionals and other support staff.

The task force in Texas recommended expanding its loan repayment program to include recipients of loans from out-of-state banks. Iowa proposed the expansion of continuing education opportunities for health care professionals at the local level as well as cross-training and retraining for nurses. Establishing a scholarship program for allied health professionals and nurses was recommended by the Georgia task force.

To provide an incentive for the practice of obstetrics in rural areas, Georgia recommended malpractice subsidies for physicians specializing in obstetrics, pediatrics, general internal medicine, and family practice. Iowa recommended changes in medical liability laws, including a cap on noneconomic losses or further restrictions on the statute of limitations to encourage physicians in rural areas to provide obstetrical services.

Emergency Medical Services. Several commissions and task forces sought to improve emergency care in rural areas by increasing the number of EMS providers through greater access to training and by improving coordination of emergency services. The rural health task force in Iowa recommended additional funding for training and equipment. In an effort to increase the number of EMS providers the Washington task force proposed increasing the flexibility of EMS provider standards. To make it easier for residents to become certified, Texas recommended that education for EMS providers be provided by its health department. Texas also proposed a statewide trauma system that would include three levels of expertise and established referral patterns, thus making better use of existing resources.

Reimbursement. With many rural areas experiencing financial problems, several commissions and task forces recommended increasing reimbursement rates for health care services in these areas. Washington state recommended increasing payments to rural providers under its Medical Assistance Program, while Texas advocated that Congress eliminate the urban/ rural reimbursement differential and expand the disproportionate share methodology to include additional considerations for rural hospitals. Alabama suggested increasing the prenatal global fee under Medicaid in order to encourage more physicians to deliver babies.

Conclusion

State commission and task force reports indicate that states are beginning to address the health care problems facing rural areas. In most cases the recommendations focus on raising the overall quality of health care for rural residents, primarily through increasing access to services and providers. The recommendations range from increasing the number of providers through scholarship and loan forgiveness programs to enhancing support services by developing volunteer transportation networks.

Although states are experiencing similar problems with respect to health care delivery in rural areas, each state has developed solutions that take into account the unique needs of their rural communities. The summaries of state rural health commission and task forces that follow include information on charge and purpose, membership, findings and recommendations, and implementation and outcomes, when available.

Alabama: Rural Health Task Force

Date

April - December 1989

Purpose ***and Background***

House Joint Resolution No. 60, approved by the Alabama Legislature in February 1989, created a task force to study the state's rural health care crisis. The resolution mandated that the task force develop possible solutions to the problems facing the rural health care system, with particular focus on the financial troubles of rural hospitals and the shortage of obstetrical and other health care services in rural areas.

Membership

The forty-six members of the task force represented health-related organizations, health care providers' associations, political and advocacy groups, the insurance industry, and state and federal agencies.

Findings

- Between June 1987 and June 1989, eleven hospitals closed across the state.
- Nearly 60 percent of the state's residents live outside urban centers, yet only 33 percent of the state's physicians practice in rural areas.
- The number of obstetricians and family practitioners who deliver babies declined by more than 50 percent, from over 400 to leas than 200.
- More than one-third of Alabama's counties do not have a hospital with obstetrical services available.
- In 1989 the average occupancy rate for sixty small rural facilities was 35 percent, with some rates as low as 7.6 percent.

Recommendations

Recommendations of the task force focused on areas such as alternative uses, health personnel shortages, technical assistance, and financing.

Altema tive Uses

- Allow hospitals to provide temporary respite care to the elderly, physically handicapped, and the mentally impaired for up to fourteen days a quarter per patient, without certificate of need review.
- Secure Medicaid reimbursement for rural hospitals that provide adult care in the hospital setting.
- Establish a state program to supplement the income of elderly, financially dependent Alabamians who need domiciliary care and who reside in hospital domiciliary care facilities, with monthly supplemental income payments of up to $200 being made directly to the hospitals.

Health Personnel Shortages

- Revise the Medical Scholarship Act to include a cancelable Rural Incentive Loan that the Board of Medical Scholarship Awards could issue to physicians completing their clinical residencies. These physicians would agree to enter primary care practices in rural, medically underserved areas of the state and to accept Medicaid and Medicare patients. Loans would be issued from the Rural Incentive Loan Fund, which would be created as the new depository for scholarship loan repayments.
- Encourage Alabama medical schools to admit a specific percentage of applicants with rural backgrounds who express a strong interest in returning to practice in rural Alabama.

- Revise the Scholarships for Professional and Technical Personnel at Public Hospitals Act so that funds raised by public hospitals for nursing and ancillary personnel scholarships could be matched by the Board of Medical Scholarship Awards on a dollar-for-dollar basis through a contractual agreement.
- Create a Family Practice Rural Health Board to increase the supply of competent family physicians in rural, medically underserved areas.

Technical Assistance

- Provide interested rural hospitals with a comprehensive, up-to-date list of hospital management consulting firms and other technical resources available in Alabama.
- Develop a comprehensive strategic plan, initiated by the Alabama Department of Public Health, that identifies solutions to rural health care problems and ways those solutions can be implemented and evaluated.
- Facilitate the arrangement of interim consortium agreements among hospitals, through which the hospitals would share certain services that may be lacking in a rural area and avoid duplicative services.

Financing

- Expand Medicaid coverage to 130 percent of the federal poverty level for pregnant women and children up to eight years of age.
- Increase the Medicaid global fee for prenatal, delivery, and postpartum care to $1,200 for obstetricians and family physicians, and to $960, or 80 percent of that level, for certified nurse-midwives.
- Increase Medicaid reimbursement to physicians and hospitals for primary and preventive outpatient care services.
- Establish a grant program to subsidize the medical professional liability insurance premiums of physicians who provide obstetrical services in rural areas.

General Long Range

- Complete a long-range study, to be directed by the Alabama Medicaid Agency, on ways to increase eligibility for health services, particularly the impact of decoupling Medicaid from the Aid to Families with Dependent Children program. Explore the possibility of a Medicaid buy-in program for the uninsured.
- Develop a comprehensive Alabama Health Care Plan, available to every Alabamian, to include core health services such as preventive care, reproductive care, emergency care, basic primary care, chronic disease care, and home health care.

Implementation/ Outcomes

The final report, dated December 1989, was submitted to the Alabama State Legislature.

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Alaska: Governor's Interim Commission on Health Care

Date

September 1987 - September 1988

Purpose and Background

The commission was mandated by the Governor through Administrative Order No. 100 in response to concerns over the high cost of medical care in Alaska. The commission was charged with recommending changes in laws, regulations, and policies necessary to reduce and/or contain the cost of health care in Alaska and to increase access to health care for Alaskans who lack the resources to obtain adequate health care.

Membership

The eleven-member commission was composed of the Department of Health and Social Services Commissioner, and representatives from the state legislature and the public who were knowledgeable in the provision of health care services in the state.

Findings

- No other state has a higher mortality rate for infants between the age of one month and one year.
- Medical liability premiums more than doubled between 1985 and 1988.

Recommendations

The commission developed recommendations for improving health care access and managing health care costs in Alaska. The specific issues addressed in the recommendations are improving health care for pregnant women and children, stretching the safety net for impoverished adults, health insurance, access to long-term care, financing and reimbursement, and planning for the future.

Improving Health Care for Pregnant Women and Children

- The legislature should immediately expand Medicaid eligibility to pregnant women and children up to five years of age who have family incomes that do not exceed 100 percent of the federal poverty level.
- The Department of Health and Social Services should develop a system of care coordination for pregnant women, targeting women with high-risk pregnancies. The legislature should adopt the Medicaid option of case management for pregnant women.
- Comprehensive health screening should be guaranteed to all of Alaska's infants, toddlers, preschoolers, and students to identify problems as soon as possible and to prevent more expensive treatment later.

Stretching the Safety Net for Impoverished Adults

- The state should reinstate the General Relief Medical (GRM) program for outpatient care and prescription drugs, limiting outpatient visits to one per month and recouping GRM dollars from Medicaid for recipients who eventually qualify for Medicaid by establishing Supplemental Security Income or Adult Public Assistance (APA) disability status.
- The state should raise the GRM eligibility ceiling to allow more coverage--up to the Aid to Families with Dependent Children (AFDC) need standards, if feasible.
- Alaska should adopt the Medicaid unemployed-parent option (including the AFDC cash component, if economically feasible).
- The state should support demonstration projects and other community efforts to provide primary and preventive health care to low-income Alaskans with no third-party coverage.

Health Insurance

- A state working group should explore and develop health insurance plans for medically uninsured Alaskans, making a written report to the Governor and legislature within twenty-four months.
- Medicaid coverage should be extended to families terminated from AFDC due to increased earnings. If federal welfare reform lengthens the extension period further, Alaska also should pick up that option,

Access to Long- Term Care

- The state should plan, develop, and fund a home- and community-based service system for persons in need of long-term care as an alternative to less desirable and more expensive institutional care.
- The Indian Health Service should be encouraged to participate with the state in funding a rural demonstration project to recruit, train, and supervise chronic care home health aides for rural villages.
- The Department of Health and Social Services and the Department of Administration should pursue, incrementally, case management services for groups in need of long-term care.
- The state should adopt regulations requiring that admission standards for residential and nursing home care be consistent for all people whose care is subsidized by the state.

Financing and Reimbursement

- The legislature should amend the certificate of need statutes to enhance the effectiveness of the certificate of need process in avoiding unnecessary health care costs, and should encourage development of community-based services.
- The Medical Care Advisory Committee, the Department of Health and Social Services, and the Medicaid Rate Commission should evaluate case mix reimbursement as a new method for setting reimbursement rates for nursing homes.
- The Governor should appoint an interagency working group to reduce unjustified inconsistencies in state health care purchasing policies.
- The commission supported the concept of mandatory provision of inpatient and outpatient substance abuse and mental health treatment in employer-offered health insurance packages.
- The state should adopt the Medicaid option for coverage of prescription drugs.

Planningfor the Future

- The legislature should fund additional positions in the Department of Health and Social Services for data analysis, cost management, and policy development. In addition, the legislature should increase the appropriation for the Medical Care Advisory Committee so it can become more effective.
- The Department of Health and Social Services and the Older Alaskans Commission should investigate ways to reduce barriers to coordinating grant programs administered by the two agencies.
- The state should endeavor to coordinate planning and provision of health care with federal agencies.

Implementation/ Outcomes The commission's final report was transmitted to the Governor. As a result of this report the Medicaid prescription drug option was adopted.

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Arkansas: Governor's Task Force on Rural Hospitals

Date August 1988 - April 1989

Purpose and Background ***The*** Arkansas Governor's Task Force on Rural Health, established by the Governor in 1988, was established based on the belief that the serious problems facing rural hospitals needed to be addressed and could be changed with a concerted effort by government, health institutions, health professionals, and communities.

Membership ***The*** twenty-two members of the commission represented elected officials, hospital administrators, state health officials, hospital board chairs, and physicians.

Findings

- Between 1976 and 1985 one hospital closed in Arkansas. Between 1985 and 1988 seven hospitals closed.
- All the hospitals that have closed in Arkansas were in rural areas and all had fifty or fewer beds.
- The Arkansas Hospital Association is expecting five to ten more small, rural hospitals to close by 1990.

Recommendations ***The*** Governor's task force made numerous service delivery, manpower, financing, and legislative recommendations to improve rural health care.

Service Delivery

- Explore networking opportunities to enhance efficiency and cost-effectiveness.
- Develop exclusive provider contracts between the governing boards of rural hospitals and local businesses.
- Create a pilot program to allow hospitals with ninety-nine beds or fewer to utilize up to 50 percent of licensed beds as swing beds.

Manpower

- Establish special student recruitment efforts for applicants from rural areas, federally designated health manpower shortage areas, and/or areas otherwise determined to have an appropriate indication of need.
- Expand family practice residency training to encourage more rural practice.
- Encourage expanded outreach programs for nursing.

Financing

- Expand Medicaid eligibility from 29 percent to 35 percent of the federal poverty level.

- Implement by 1990 the Arkansas Medicaid Program proposal to increase payments by 9 percent to hospitals serving a disproportionate share of Medicaid patients.
- Explore the creation of a transition fund to aid in the closure or conversion of rural hospitals.

Legislation

- Fund an effort to assist rural communities in developing an appropriate and financially stable health care system.
- Enact legislation to allow county-owned and municipal hospitals to participate in joint ventures.
- Enact legislation for the establishment of voluntary rural hospital alliances.
- Create a state appropriation to provide reimbursement to hospitals that provide a disproportionate share of medical care to patients ineligible for Medicaid and unable to pay for care.

Implementation/ Outcomes

The task force findings were recently presented to the Governor.

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Georgia: Rural Hospital Task Force

Date

September 1987 - April 1988

Purpose *and* *Background*

In spring 1987, in response to reports of potential financial failure of some rural hospitals and the related effect on the availability of medical care in rural areas, Governor Joe Frank Harris requested the state Health Policy Council and the state Health Planning Agency to conduct a study of Georgia's rural hospitals. In August 1987, following the release of a reference paper reporting the findings of the study, the Health Planning Agency authorized the creation of a Rural Hospital Task Force. The charge of the task force was to identify and study the experience of Georgia's rural hospitals,with the ultimate goal of producing recommendations to strengthen any weak links in the rural health care delivery system.

Membership

The Rural Hospital Task Force was composed of twenty-one members representing local government, hospitals, medical and professional associations, medical schools, and state and local agencies.

Findings and Recommendations

The task force found that many of Georgia's small, rural hospitals faced an uncertain future. The recommendations emphasized the need for a coordinated, integrated, and well-planned approach as a vital element in the survival of these institutions. The specific recommendations focused on the identified critical areas of community health care needs, indigent care, regulation and reimbursement, access to capital, and the recruitment and retention of health care professionals.

Community Health Care Needs

- Urge the establishment of an Office of Rural Health located within the Department of **Community** Affairs. Services provided through this office

should include technical assistance to rural communities and rural hospitals to facilitate a local planning process that would identify the needs and capabilities of the local community.

- Urge the creation of a strong statewide planning effort to provide guidance through the state health plan to rural communities and rural hospitals to assure that those health services best provided in the local area are available and accessible to all residents and are provided in a cost-effective manner.
- Urge the state Health Policy Council to provide leadership in developing a mechanism to examine issues affecting health care including, but not limited to, rural health care.

Indigent Care

- Oppose the adoption or creation of any policies that the state or any of its departments might address to encourage a two-tiered system of basic health care delivery in the state of Georgia.
- Increase, as appropriate, the services provided by the Health Department and Primary Care Centers when such expansions are needed to assure access and availability, and when other alternatives are not available in that community.
- Urge the state to expand Medicaid to include any and all options.
- Support and encourage the development of public and private policies that contain incentives to employers to provide insurance to all their employees.

Regulation and Reimbursement

Recommendations were divided among the specific areas of state health planning, regulatory services, reimbursement, and peer review organizations. The recommendations include:

- Increase the maximum bed size for swing bed facilities allowed by federal guidelines from under fifty beds to under 100 beds.
- Urge the state Health Planning Agency, Department of Medical Assistance, and Department of Human Resources to work together to define "heavily skilled nursing beds" and to consider separate criteria to provide for heavy skilled nursing care beds to Medicaid and Medicare recipients only in rural disproportionate share hospitals.
- Urge the Office of Regulatory Services to review its survey schedules and, whenever possible, to consolidate them in an effort to reduce the reporting burdens of hospitals.
- Encourage the Department of Medical Assistance (DMA) to study the possibility of increasing levels of reimbursement for a range of services to increase physicians' participation in the Medicaid program.
- Urge the Department of Medical Assistance to provide upon request (in conjunction with the Georgia Hospital Association as appropriate) an educational program for hospital administrators concerning the policies, procedures, and rationales of the Medicaid reimbursement process, with special consideration to the specific concerns of rural providers.
- Urge the Georgia Medical Care Foundation to develop a more timely appeals process.
- Urge the federal Health Care Financing Administration to review its policies governing the selection of physicians to be reviewed. A different

mechanism for ratios of charts to be reviewed for urban and rural physicians should be developed to address the disparity of review frequency currently experienced by rural physicians.

Access to Capital

- Urge the state to create a capital fund for hospital capital needs other than equipment, from which low-interest loans can be obtained by rural hospitals meeting criteria to be developed by the state Health Planning Agency.

Recruitment and Retention of Health Care Professionals

- Urge the state Health Policy Council to appoint an Interagency Council on Rural Health for a period of one year to address/monitor the implementation of the Rural Hospital Task Force's recommendations and to further research the concerns not previously or comprehensively explored by the existing task force.
- Encourage individual hospitals, counties, and local financial institutions to consider subsidizing rural malpractice premiums for those physicians specializing in obstetrics, pediatrics, general internal medicine, and family practice.
- Urge the creation of a scholarship program for allied health and nursing professionals who choose to practice in rural Georgia, patterned after the physician scholarship program already in place.
- Urge state colleges and universities providing education and training for health professionals to expand their efforts to design their programs in ways that promote rural practice and support rural practitioners.

Implementationl Outcomes

The final report of the task force was submitted to the Governor who endorsed a number of the recommendations as well as indicated that a number of them would be implemented. Highlights from the Governor's response to the recommendations developed by the task force are: incorporating the recommendations into ongoing activities, where feasible; stressing the expansion of the state's Medicaid program to address rural health issues; and cautioning the state Health Planning Agency to be sensitive to the problems of any increased reporting requirements for hospitals.

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Illinois: Rural Health Task Force

Date

June 1988 - April 1990

Purpose ***and Background***

Established in June 1988 by the Lieutenant Governor, the group was charged with creating a legislative and administrative plan to improve access to rural health care in Illinois. The twenty-two members met seven times during a twenty-two month period to define issues and propose recommendations to the Illinois General Assembly. The task force solicited comments from more than 5,000 interested individuals and responded to many of these concerns.

Membership

Members of the task force represented rural health care practitioners, physicians, nurses, university and medical school personnel, and agricultural interests.

Recommendations

More than thirty recommendations were made in a range of areas, including emergency medical services, rural health clinics, local health department coverage, incentives for health professionals, medical liability insurance, transportation to medical care, health planning, and community health centers.

Emergency Medical Services

- Increase the use of Advanced Life Support (ALS) field-registered nurses in rural communities to improve patient outcomes in prehospital emergency situations.
- Develop areawide ALS ambulance services to coordinate with the dispatch of locally based primary response ambulances.

Rural Health Clinics

- Promote the federal rural health clinic program to medical providers in rural Illinois and identify and provide technical assistance to providers interested in meeting certification requirements.

Incentives to Health Professionals

- Establish an education loan repayment program for health professionals who establish practices in areas with health personnel shortages.
- Provide new funding to create a program parallel to the medical scholarship program that would provide scholarships to other types of health professionals as an incentive to practice in rural areas.
- Raise Medicaid reimbursement rates as an incentive to physicians to practice in underserved areas.
- Establish an information network to provide consultation, referral, and reference services for physicians in rural areas.

Medical Liability Insurance

- Explore mechanisms implemented or proposed in other states for the efficient resolution of malpractice claims.
- Enact a tort reform statute to establish a cap on noneconomic damages in malpractice lawsuits.
- Promote the development of appropriate public sector insurance risk pooling.
- Encourage physicians to offer obstetrical services in rural Illinois by promoting the development of subsidies for malpractice liability insurance.

Transportation to Medical Care

- Provide funding to allow local health departments or federally designated community health centers to offer areawide medical transportation services to eligible public assistance recipients.

Health Planning

- Develop demonstration projects in rural communities to plan and deliver health and social services in order to meet identified community needs.

Community Health Centers

- Develop and fund three demonstration community centers in health personnel shortage areas by providing start-up support and other technical assistance. One or more of these should be developed in communities that have a hospital in transition.
- Extend the new obstetricians' incentive program statewide to encourage the maintenance of obstetric care in rural communities.
- Encourage coordination and avoid duplication of services among community health centers, public health departments, local medical providers, and social service agencies, particularly in rural communities,

Implementation1 Outcomes

The task force submitted the report to the Governor, Lieutenant Governor, and the Illinois General Assembly in an effort to increase access and quality of rural health care in the state.

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Iowa: Task Force on Rural Health

Date

June - November 1989

Purpose ***and Background***

The Iowa Task Force on Rural Health was established in summer 1989 by Governor Terry E. Branstad. The task force was charged with identifying a set of goals and strategies to improve the support of Iowa's rural health care system now and in the future.

In an effort to thoroughly explore more areas, the task force divided into three subcommittees: health care delivery systems, personnel, and high-risk groups. The subcommittees gathered supporting materials that reflected both the present situation and what is likely to happen in the future. With this information, each subcommittee identified critical issues and developed major areas to frame its recommendations.

Membership

The task force's twenty-three members were representative of health professions, agencies, farm organizations, industries, and local government. Nineteen different counties were represented.

Findings

Health Care Providers

- Approximately 170 communities are actually recruiting physicians.
- More than 20 percent of Iowa's family practitioners are over sixty years of age.
- In 1988, fifty-two physicians completed residency training programs in Iowa, but only twenty-eight (54 percent) stayed on to practice in Iowa.

Professional Educational Programs

- ***No*** certified registered nurse anesthetist education programs exist in the state.
- Only one occupational therapy training program is offered in the state.

Obstetrical Services

- Sixteen counties have no hospitals with obstetrical services for low-income women. Some low-risk pregnancy patients travel as many as fifty miles to another county with hospital delivery services.

Occupational and Farm Safety

- Federal expenditures for occupational safety amount to $.30 per agricultural worker, compared with $4.34 per worker for other occupations.

Emergency Medical Services

- Seventy-five percent of ambulance service is on a volunteer basis.
- The number of Emergency Medical Service (EMS) personnel in Iowa has decreased by 40 percent since federal emergency services funding ceased in 1981.

Recommendations

Health care in rural Iowa is seen as a vital component of a community's ability to expand and develop. A community's economic development depends on its ability to attract and keep industry and residents. Regardless of location, rural Iowans should have reasonable access to a basic set of primary care and emergency medical services. Several recommendations were made by the task force.

Access

- Hospitals should be given additional regulatory and payment flexibility in the delivery of services. Rural hospital networks also should be encouraged to allow development of information system linkages between small hospitals and referral centers.
- Planning should involve all segments of the community, including state government support through leadership programs, as well as grants and loans for implementation and evaluation of community plans. Grants and loans are considered essential components of providing health care in rural areas.
- State government, together with private industry, consumers, and health care providers, should outline a state plan to improve access to health services in rural areas. The state also is encouraged to expand and adequately fund the state Office of Rural Health.
- Local funding for EMS training and equipment should be matched with state funds.
- The state and counties, with the support of telephone companies, should consider implementing an emergency 911 service.
- The Medicaid prospective payment system should be re-evaluated to ensure that all rural providers receive adequate payment for services rendered to Medicaid patients.

Health Care Personnel

- Create a state income tax credit to encourage health care professionals to practice in Iowa.
- Establish state low-interest loans and payment-forgiveness programs to encourage health care professionals to practice in Iowa.
- Develop innovative health care delivery programs at the local level with state matching funds.
- Develop tort reform legislation that would cover obstetrical services and encourage physicians to provide obstetrical services.

- Develop programs that would inform and encourage high school Students to pursue careers in all health care professions and remain in Iowa.
- Develop and implement a health care career day program for use at the local level.
- Encourage college faculty who teach health care professional courses to gain first-hand experience regarding health care delivery in rural areas.
- Expand the continuing education opportunities available for health care professionals at local levels, with provisions for cross-training and retraining opportunities for registered nurses.
- Encourage medical and osteopathic training programs to include exposure to rural needs and settings.
- Increase quota requirements for Iowa students in health care training programs in areas in which the demand is greater than supply.
- Provide the additional funds necessary to expand training opportunities at colleges and universities in health fields with identified shortages.

High-Risk Groups

- Encourage communities to provide support services to the elderly and handicapped to assist them in remaining in their own homes. Services should include homemaking; nutrition programs; reassurance programs; and assistance with home maintenance, repairs, and necessary physical modifications.
- Use volunteers to assist in setting up and providing needed support services such as transportation.
- Increase the number of volunteer drivers by providing limited liability or other incentives such as state tax credits.
- Ensure that a network of services exists for regular prenatal care and delivery, including obstetrical emergencies and identification ofhigh-risk pregnancies.
- Explore and establish alternative methods for providing paramedical and other necessary services.
- Encourage physicians in rural areas to provide obstetrical services through changes in medical liability laws, especially a cap on non-economic losses or further restrictions on the statute of limitations.
- Encourage the use of agriculture health and safety devices such as roll-over protection devices.
- Encourage the development of incentives such as insurance rate modifications, discounting by equipment dealers, and tax credits for use of protective equipment.

Implementation/ Outcomes

The task force findings were presented to the Governor.

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Kansas: Rural Development Action Plan

Date

January 1986 - August 1989

Purpose ***and Background***

The Rural Development Action Plan was developed at the request of the Joint Economic Development Committee. The document is an effort to assess the current status of rural Kansas and present policy recommendations to assist local economies. Kansas Incorporated, the producer of the report, is a public-private partnership created by the 1986 Kansas Legislature. Kansas Incorporated serves as an adviser to the cabinet and legislature, analyzing the state's tax, regulatory, and economic development policies. It conducts research and recommends actions to produce a growing Kansas.

Membership

Kansas Incorporated's Board of Directors consists of fifteen members who direct its activities. It is co-chaired by Governor Mike Hayden and Eric Jager of Kansas City. The board's membership includes the following industries: oil and gas, finance, aviation, agriculture, and a value-added manufacturing firm. Additional representatives include labor, the Kansas Board of Regents, the Commanding General of the Kansas Cavalry, the Secretary of the Department of Commerce, and holders of the four legislative leadership posts.

Recommendations

Several recommendations were offered for consideration by the Joint Economic Development Committee dealing with the need for community-based and regional strategies, the need for better information and data, and other potentials for rural economic development.

- Initiate a four-year program to develop community and regional rural development strategies throughout the state of Kansas. Within this new program the following would be included:
  - Establish a grant program for community strategic planning assistance to provide funding to city-county economic development organizations for implementation and development of countywide economic development strategies.
  - Establish a three-year, $3 million program with grant awards of $50,000 each to sixty applicants.
- Establish uniform regions of state-funded organizations for the delivery of community and business assistance.
- Colocate the regional and field offices of state-funded economic development agencies.
- Establish a strategic planning database to monitor the economic and demographic conditions of rural counties and communities in Kansas.
- Assist communities to develop strategies and programs that would recruit workers and their families to rural communities.
- Establish a program to identify and develop business creation and diversification strategies for counties with a dependence on one major industry, sector, or firm.
- Conduct in-depth research and analysis that would allow growing and economically diversified rural communities to identify factors that lead to success in rural Kansas.

Implementation / Outcomes

While the recommendations from this report have not yet been implemented, Kansas has put considerable effort into improving the status of rural health within the state. Several recommendations from the Governor's Task Force on the Future of Rural Communities have been implemented. In

addition, the University of Kansas, and Kansas State University recently have launched several new efforts. These initiatives suggest that Kansas already has recognized the need to broaden growth opportunities in rural communities and ensure quality health care for rural residents.

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Minnesota: Access to Hospital Services in Rural Minnesota

Date

January 1988 - February 1989

Purpose and Background

This report was prepared for the Minnesota Legislature in response to a 1988 legislative mandate. The health commissioner was charged with studying the hospital system in the state and reporting the findings to the legislature. Those findings covered the financial conditions of rural hospitals, including the identification of regions in the state where the closing of a financially distressed hospital would result in access problems for rural residents.

Findings

- From 1984 to 1987, one-third or more of the state's ninety-five hospitals with fewer than fifty beds had negative net income.
- In each year, one-fourth of these hospitals had cooperative losses exceeding 4 percent of operating revenues.
- Currently, 19,000 Minnesotans in fourteen northern counties must travel more than thirty minutes to a hospital.
- Twelve rural hospitals are in precarious financial condition. If all twelve closed, 37,000 Minnesotans would have to travel more than thirty minutes to a hospital.

Recommendations

The health commissioner's report made several recommendations aimed at increasing access to health care for rural Minnesotans. Recommendations are aimed at keeping existing health care facilities open, establishing funding assistance programs, and improving the availability of transportation.

- Establish a hospital subsidy fund to preserve access in geographically isolated areas. Eligibility for funds would depend on the impact of the hospital closure on geographic access to hospital services, the hospital's degree of financial stress, proof that other revenue sources have been exhausted, receipt of other grant funds, and perhaps matching local funds.
- Establish a one-time rural health transition grants program for rural hospitals.
- Study the appropriateness of creating a new category of health care facility in Minnesota. In addition, the Minnesota Department of Health should develop appropriate regulatory standards for these facilities to provide emergency medical services and a minimum level of acute care services.
- Assess the impact of travel times to hospitals on inpatient survival. Various lengths of transportation time to the nearest hospital-such as thirty, forty-five, or sixty minutes-should be studied.

- Assess the need for maintaining a four-bed cap on hospital swing beds, given the state's need for long-term care beds.

Implementation1 Outcomes

The report was completed in March 1989 and presented to the legislature. This report has been important in shaping the overall policy response. Currently, there is a bill before the legislature to provide funding for emergency medical services, health personnel, and rural hospital services directly related to the recommendations of this study. Unfortunately, funding remains an obstacle. While it is likely this bill will pass, it also is likely that needed funds will not be appropriated.

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Nebraska: Task Force on Rural Health

Date

1987

Purpose ***and Background***

Due to the efforts of Senators Wesley and Schellpeper, the Nebraska Task Force on Rural Health was created to study the rural health care system in the state and to develop recommendations to address identified problems.

Membership

The task force was composed of several rural health administrators, rural health physicians, and representatives of the Nebraska Medical Association, the Medical Center of the University of Nebraska, health care professional associations, nursing homes, and the Department of Health.

Findings

- On average, rural hospitals/providers earned 40 percent less than those in urban areas,
- At any given time, there are as many as forty communities trying to attract a physician.

Recommendations

The task force developed recommendations that address a number of rural health issues, including the reimbursement system, the peer review organization process, health care provider shortages, and hospital viability.

- Enact a legislative resolution asking the federal government to establish a reimbursement schedule for rural hospitals that is equivalent to the one used for urban hospitals,
- Study the effectiveness of the peer review organization;
- Enact a student loan program for nurses who will practice in rural areas;
- Establish a health department program to assess community health needs and assist in resolving rural health care problems;
- Maintain full funding for current nursing programs, the family practice program at the Medical Center, and the Lincoln Medical Education Foundation; and
- Continue and maintain full funding for the Rural Health Manpower Act and the Medical Student Assistance Act.

Implementation/ Outcomes

Based upon two of the recommendations, legislation has been developed and introduced in the state legislature. Legislative Bill 994 proposes to create an Office of Rural Health and Legislative Bill 357 proposes to provide

scholarships to rural health residents for nursing schools/programs. Similar legislation was introduced in 1989 and vetoed.

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South Carolina: The Governor's Task Force on Rural Primary Care

Date

1989-1990

Purpose ***and Background***

The commission was established to provide the leadership of South Carolina with the information necessary to develop a strategic plan for a comprehensive care delivery system that would ensure all state residents access to quality health care.

Membership

The commission consists of representatives from the University of South Carolina's School of Public Health, the Health and Human Services Financing Commission, the Department of Health and Environmental Control, the State Development Board, and professional health associations. Some of the most challenging goals of the commission are to assess South Carolina's current rural health care system, develop a design for its future needs, and create a strategic plan to implement the program.

Findings

In order to develop a feasible rural health system of quality, the commission analyzed the strengths and weaknesses of previous efforts. It identified the following as major issues of concern:

- Lack of adequate numbers of health care providers;
- Inappropriate organizational models of health care;
- Inadequate systems linkages among primary, secondary, and tertiary levels of care;
- Lack of state-of-the-art management techniques, technology adapted for rural areas, and facilities designed for the unique needs of a rural community;
- Failure to integrate public- and private-sector financing or to put into place incentives to ensure long-term viability of the health care system;
- Lack of specific services or combinations of services appropriate for rural areas such as emergency medical services, environmental health services, community outreach services, home health care, and transportation; and
- Failure to integrate rural community health care professionals into regional and statewide systems of continuing medical education, student training, and patient referral in order to ensure retention, intellectual stimulation, and a continuing source of new personnel.

Implementation/ Outcomes

The final South Carolina rural health care system plan has not been developed at this time.

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Texas: Special Task Force on Rural Health Care Delivery

Date

March 1988 - January 1989

Purpose ***and Background***

The Special Task Force on Rural Health Care Delivery was created by a Senate Concurrent Resolution of the Seventieth Texas Legislature in June 1988. The task force conducted eleven public hearings in Austin, Amarillo, Odessa, Texarkana, Tyler, Brownsville, Warm Springs, and Abilene. The task force received testimony from more than 225 representatives of local, county, and state governments; the federal government; physicians, nurses, and allied health professionals; hospital administrators and other health care providers; clergy; business leaders; advocacy groups; and consumers of health care. As a result, the task force appointed five subcommittees to study issues identified as being crucial to the continued viability of the rural health care delivery system in Texas.

Membership

The nine-member task force was appointed by Governor William P. Clements Jr., Lieutenant Governor William P. Hobby, and Speaker of the House Gibson D. Lewis. The nine members represented both elected officials and providers.

Findings

Hospitals

- Since 1984 Texas has lost sixty-five hospitals.
- Texas alone has experienced 20 percent of all U.S. hospital closures.
- Fifty counties in Texas do not have a hospital.

Providers

- Fourteen counties do not have a physician. These counties cover approximately 18,780 square miles, an area larger than nine states and the District of Columbia.
- Fourteen counties have no pharmacist, thirty-three have no dentist, and twenty-seven have no nursing home.

Obstetrical Services

- Hospital obstetrical care is not available in ninety-two of 254 counties.
- Sixty-one percent of general and family practitioners either have curtailed or have abandoned obstetrical care. When asked why they no longer provided that service, practitioners attributed service termination to medical malpractice issues.
- Twenty-five percent of obstetricians and gynecologists have eliminated or limited obstetrical procedures; 45 percent have eliminated or limited high-risk obstetrics.
- Nine low-birthweight babies are born each day in rural Texas.

Recommendations

The task force made recommendations in the areas of the five subcommittees: emergency medical services (EMS)/trauma care, manpower, financing

of rural health care, regulatory restrictions, and obstetrics and medical malpractice liability. The task force also made recommendations on federal issues and other special issues.

Emergency Medical Services/Trauma Care

- Urge legislators to establish a trauma registry and examine existing state and federal sources for funding it. In addition, clarify the fee exemption for EMS volunteers and EMS volunteer providers.
- Urge the legislature to establish a statewide trauma system that includes all qualified hospitals statewide. Included in the system should be three levels of expertise with established referral patterns and a mechanism to provide grants and funds for the purchase of capital equipment.
- Encourage the Department of Health to continue providing EMS education, continuing education, and alternative testing/retesting schedules to facilitate participation by rural citizens. This step would allow EMS providers access to training programs funded by the Departments of Highways and Transportation.

Personnel

- Encourage the Higher Education Coordinating Board to maintain a minimum annual repayment level of $9,000 per year for physicians in the Physicians Student Loan Repayment Program.
- Urge the legislature to amend the Physicians Student Loan Repayment Program to allow participation of health care personnel with loans from out-of-state banks.
- Create an interagency effort among the Texas Higher Education Coordinating Board, Rural Medical Education Advisory Board, medical schools, nursing schools, and schools of allied health sciences to improve and expand programs.
- Encourage the Texas State Board of Education to reclassify health occupation education classes as upper-division science courses in high school.
- Urge Texas medical schools to include a rural physician on their admission committees.

Financing Rural Health Care

- Encourage Congress to eliminate the urban-rural reimbursement differential for hospitals and physicians, with special attention given to the wage differential for hospital reimbursement changes.
- Urge the state legislature to establish a Medicaid diagnostic-related group methodology based on three peer groups.
- Encourage the state legislature to appropriate sufficient funds in the Medicaid program to increase the standard dollar amount to $1,583.
- Study the feasibility of establishing a special mechanism for supplemental payments to hospitals in which the Medicare patient census exceeds 110 percent of the national average Medicare hospital census. One option would be a sliding scale for hospitals that provide a progressively greater percentage of Medicare services.
- Expand disproportionate share hospital methodology to provide additional consideration for rural hospitals.

Regulatory Restrictions

- Develop multipurpose health care facilities and service diversification at existing facilities in rural areas to facilitate the use of existing facilities. State agencies should assist any facility seeking waivers necessary to facilitate implementation of pilot diversification projects.
- Expand Medicaid coverage to include swing bed care. In addition, the Board of Human Services should develop a program to facilitate the use of unused hospital beds by easing regulatory restrictions on the licensing of long-term care beds.
- Develop an interagency effort to identify and eliminate any duplication of regulatory surveys and implement measures to ensure consistent interpretation of rules and regulations by survey teams. The Texas Department of Health should serve as the lead agency.
- Develop a quality assurance and utilization review program for Medicaid hospital admissions. The program should use practicing physicians who are representative, in the hospital setting, of the same locality and specialty as the physicians being reviewed.

Obstetrics and Medical Malpractice Liability

- Establish a system of care within the existing framework of administrative agencies to expand access to nutritional programs and other necessary prenatal care.
- Examine the feasibility of calculating medical malpractice premiums based upon a case mix formula. The Texas Board of Insurance should serve as the lead agency in this strategy.
- Place physicians and other health care providers who provide obstetrical care for indigents, are performing services under contract, or are agents or employees of those under contract with the state or its agencies under the umbrella of the limited liability of the Texas Tort Claims Act.

Federal and Other Special Issues

- Develop model initiatives that would include public/private resource teams to address rural health and economic development needs.
- Focus special attention on the threat to health and safety of rural residents from causes such as groundwater contamination, toxic chemicals, unsafe farm machinery, job stress, and lack of basic services.
- Urge Congress to enact loan repayment programs and support rural education programs to encourage physicians, nurses, and allied health professionals to practice in rural areas and facilities.
- Urge Congress to provide sufficient funding to enhance communication and transportation linkages with more centrally located health resources, and to develop regional service networks.

Implementation/ Outcomes

The recommendations were presented to the legislature in January 1990.

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Washington: Access to Maternity Care Committee

Date

January 1988 - present

Purpose ***and Background***

Private obstetrical practitioners working in Level II and Level III hospitals in eastern Washington, the portion of the state where the majority of rural communities are located, noticed an abrupt increase in the number of patients with little or no prenatal care. It soon became evident that the problem was statewide. The Access to Maternity Care Committee (AMCC) evolved from a proposal to address accelerating access problems in the state, particularly in rural areas. The major objective of the AMCC is to improve access to obstetrical services for pregnant women, particularly rural women and medically indigent women.

Membership

The committee consists of representatives from relevant state professional associations and from state agencies with responsibility for services to women and children.

Findings

- In 1985, 25 percent of all general and family physicians gave up obstetrical practice.
- In rural counties, more than 25 percent of all women received inadequate prenatal care, and an increasing number of women received no prenatal care.
- The state Medicaid program reported a decrease in the number of providers willing to accept Medicaid patients, while the number of women requiring Medicaid assistance increased.

Recommendations

As a part of the process of achieving its goal, the committee pursued two distinct activities: improving coordination and communication with the state Medicaid program, and writing and obtaining passage of a bill to enhance perinatal services provided by state government.

Working with state agencies such as Medicaid and the Bureau of Parent-Child Health Services, and interested legislative staff, a comprehensive perinatal package was developed consisting of three major components:

- Expansion of Medicaid eligibility to 185 percent of the poverty level, thus taking advantage of maximum program authority;
- Higher reimbursement to physicians providing obstetrical services to Medicaid patients; and
- Increased funds for social services for at-risk pregnant women, including the establishment of a case management program.

Implementation/ Outcomes

The committee provided a vehicle through which the private practitioners and the Medicaid agency were brought together to work toward a common goal. A trusting relationship emerged between the two entities, once the adversarial relationship was dispelled. Ad hoc working groups, which continue to meet, were formed to address the issues of provider reimbursement and improved billing and payment mechanisms.

Ultimately, the comprehensive perinatal package legislation was adopted in its entirety.

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Washington: Rural Health Care Commission

Date

March 1988 - January 1989

Purpose ***and Background***

The Washington Rural Health Care Commission was created by the legislature in 1988 to develop recommendations on current rural health care issues. The commission examined issues concerning the organization and administration of rural health care, identification of basic health care services, and financing of rural health care. Workshops and hearings were conducted throughout the state to solicit public comment regarding issues and problems associated with the availability and delivery of health care services in Washington's rural areas.

Membership

The commission's membership included several state legislators, public members representing hospitals and medical clinics statewide, and representatives of medical schools and professional health associations. In addition, two technical advisory committees were established. The Administrative and Organizational Advisory Committee was established with representatives from a variety of health-related organizations, including the State Health Coordinating Council, State Board of Pharmacy, several community health centers, and other state health department representatives, A second advisory committee for health care services was established with representatives from the American Association of Retired Persons, county hospitals, state primary care association, and private providers.

Findings

- The average occupancy rate for rural hospitals in Washington is 33.2 percent.
- In 1987, the average overall Medicaid reimbursement to rural hospitals was about 60 percent of charges.
- The average overall reimbursement to physicians is well below 50 percent of charges.
- Family practitioners pay between $16,000 and $25,000 for $1 million to $7 million worth of insurance coverage. Obstetricians' malpractice premiums range from $39,000 to $63,000 for comparable coverage.

Recommendations

The commission made eighteen recommendations to improve the overall climate of rural health care in Washington. They focused on increasing the number of providers in rural areas, increasing rural health care facilities' access to capital assistance, and ensuring that residents of rural communities have access to quality basic health care services at an affordable price.

The commission made several recommendations to address the insufficient number of rural health providers, including establishing a state loan repayment program and developing a training program to better prepare students for work in rural delivery systems. Making continuing education more accessible to rural health care professionals through telecommunications and videotapes is one recommended option. Other proposed continuing education projects included the creation of clinical sabbatical education and training activities, and the development of a rotation for professionals from smaller communities to pre-established programs. Such continuing education programs would allow employed health care professionals the opportunity to receive needed education and training.

Health Care Professionals

- Increase prescription authority to allow registered nurses to dispense medications when no pharmacy facilities are reasonably available, and to

distribute prepackaged controlled substances based on telephone orders from a physician.

Capital Assistance

- Increase medical assistance to rural providers.
- Develop a rural health financial viability policy in order to rebuild providers' financial strength through state strategic planning and financial management assistance.
- Consider exempting rural hospitals from rate review.

Access/Indigent Care

- Create a rural community health system project designed to assist rural communities in developing the means to assure access to basic health care services provided in the most cost-effective way possible.
- Create an alternative licensure facility law that would maintain basic health care services but allow communities the regulatory latitude necessary to maintain cost-effectiveness.

Access to Prenatal Care

- Improve access to maternity care through Medicaid expansion.
- Revise Medicaid reimbursement for maternity care to a rate fully adjusted for increases in malpractice premiums, and create a program to ensure the availability of low-cost liability insurance coverage for qualified practitioners who provide only prenatal care.
- Offer liability policies with premium differentials based on the number of deliveries.

Emergency Medical Services (EMS)

- Develop flexible EMS standards and enhance funding for training rural EMS volunteers.
- Establish state-provided financial assistance as a way to increase the delivery of public health services in rural counties.

Implementation/ Outcomes

The report was revised in December 1988 and the changes were adopted.

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3. State Offices of Rural Health

Introduction

The Office of Rural Health Policy was established in 1987 within the U.S. Department of Health and Human Services to work within the department and with other federal agencies, states, national associations, foundations, and private sector organizations on solutions to rural health care problems. In addition to coordinating the many players in rural health policymaking, the office also is largely responsible for collecting and disseminating information on rural health activities. Most recently, the office sponsored a workshop that, for the first time, brought together more than seventy officials representing thirty-five states and the federal government to focus on rural health. Participants shared experiences, explored strategies for improving existing offices of rural health, and discussed how new offices can be developed more effectively.

In October 1990, Congress amended the Public Health Service Act to make matching grant funds available to states in order to encourage them to establish state offices of rural health. These offices would integrate state, federal, and private sector resources to develop innovative solutions for improving access to quality care in rural communities. State capacity to respond to this federal incentive may be limited, however, due to deteriorating state fiscal conditions and the timing of state budget submissions.

Under the matching grant program for state offices of rural health the state has the authority, within a broad set of guidelines, to determine the appropriate locale of the office to receive matching funds. While all of the offices referenced in this report serve as focal points for rural health activities, they may not be officially recognized by the state as its state office on rural health under the meaning of this legislation. NGA recognizes this distinction between an official state office and a focal point of rural health activity. However, focal points and offices of rural health will constitute the same entity for the purposes of this report.

These federal efforts notwithstanding, many states have already established or strengthened existing offices of rural health. Twenty-two states have established twenty-three rural health offices that are conducting activities tailored to respond to the strengths and weaknesses of the health care system in their rural communities. Of these twenty-three offices, seventeen were established in the 1980s as rural health came under increasing focus. Several states had initiated rural health offices prior to the 1980s; North Carolina's Office of Rural Health and Resources Development was

established in 1973 and is the oldest state office. Established October 1, 1990, Mississippi has the youngest state rural health office.

Although state offices of rural health are operating throughout the United States, they are more prevalent in the West and Midwest. The NGA survey findings also indicate that these offices differ with respect to their structure and financing.

Structure and Financing of State Rural Health Offices

Nine state rural health offices were established by legislative mandate, five were established as part of state health department programs, three were established by executive decree, three were established through the state's Area Health Education Center (AHEC) activities, two were established through university medical school programs, and one grew out of a regional foundation-supported project.

Thirteen offices (Alabama, Arkansas, California, Georgia, Illinois, Iowa, Kansas, Mississippi, Nebraska, New Mexico, North Carolina, Texas, and Vermont) are housed within state health departments. Six offices (Arizona, Nevada, North Dakota, Oregon, Washington, and Wisconsin) are part of the state university system. The offices of Idaho and Montana are located in Area Health Education Centers. Northeast Wisconsin is a private nonprofit office, and the office in South Dakota represents the only joint venture of a state health department and state university.

In addition to the diversity in their administrative settings, state offices of rural health differ with respect to how they are funded. While several states fund their offices on a line-item basis through state health department budgets, a large percentage of state offices of rural health are funded by foundations and in-kind contributions. Several offices receive funds through fee-for-service agreements with health care facilities.

Role of the State Office of Rural Health

The majority of state rural health offices carry out "traditional" rural health activities:

- Providing technical assistance;
- Administering physician loan programs;
- Declaring Health Manpower Shortage Areas (HMSAs); and
- Conducting recruitment and retention activities.

Several state offices conduct research activities using outside grants or perform fee-for-service activities related to recruiting, community outreach, and technical assistance. Many programs are moving toward a more "contemporary" mode of operation-that of empowering and assisting rural communities to identify and solve their own problems.

State Rural Health Office Activities

State offices of rural health have made major contributions to improving the quality and access of health care in rural areas. Below is a sampling of the successful activities that have been undertaken in recent years.

Recruitment and Retention

- The Utah office developed both a physician education loan repayment program and a physician scholarship program. Twenty-six vacancies have been filled through these two programs.
- The office in Illinois established and administers a physician loan repayment program and a medical student scholarship program, similar to the National Health Service Corps.
- North Carolina established a physician location assistance program that has recruited more than 850 providers.
- The Nevada Health Service Corps is a loan repayment program that includes scholarships for nurse practitioners, nurse-midwives, and physician assistants.
- The Oregon office administers a state tax credit program that provides up to $5,000 in credit for physicians, nurse practitioners, and physician assistants who practice in rural areas of the state.
- South Dakota operates several initiatives, including a tuition waiver program, recruitment and retention programs for physicians and mid-level practitioners, and a freshman rural health seminar designed to attract students to rural areas.
- The Wisconsin office serves as a statewide resource for physician practice development, provides technical assistance to communities, and administers a physician loan assistance program. To date, more than 200 physicians have been recruited as a result of these activities.

Financial and Technical Assistance

- The office in Iowa administers a grant program to sponsor graduate nursing programs for Iowa nurses and support hospital-based agriculture health and safety programs.
- The Oregon office has provided $240,000 in financial assistance through grants to twenty-six separate facilities.
- Primary care and farmworker clinics receive both financial and technical assistance through the California office.
- The Kansas office provides technical assistance to communities that are seeking federal designation as a Health Manpower Shortage Area.
- Arkansas operates the Primary Care Manpower Clearinghouse and aids in designation/redesignation of both Health Manpower Shortage Areas and Medically Underserved Areas (MUAs).

Health Education

- ***The*** Idaho office provides health education to rural health professionals, especially on the subject of AIDS.
- The Rural Health Education Outreach Project aids in the development of two-way interactive television classrooms throughout the state of North Dakota.

Conclusion

The early successes of the programs and policies developed and administered by state offices on rural health clearly illustrate the important role they can play in improving the availability and effectiveness of health care in rural America. State offices also have played a major role in coordinating rural health activities to ensure maximum use of existing resources. Continued progress in affording access to quality care in rural communities can only be assured by strengthening existing offices and by establishing them where they do not exist.

Alabama: Office of Rural Health

Statistics

Established:	1989
Staff Size:	Six full-time staff
Budget:	$350,000 (approximately)
Organizational Base:	Department of Public Health

Background

An Office of Rural Health was established based on recommendations made by the Alabama Legislative Rural Health Task Force. The task force made its recommendations in December 1989, and the office was established shortly thereafter. The office was charged with providing assistance to rural health care facilities and communities through needs assessment, providing technical assistance, and serving as a link between the community and the health department.

Current Activities

While the office still is reasonably young, its influence has been felt in many areas. The primary responsibilities of the office include technical assistance to rural areas and addressing the health manpower shortage problem through a recently established Family Practice Rural Health Board.

In addition to its statewide technical assistance and recruiting activities, the office has assumed responsibility for several individual county programs such as those described below.

- In Sumter County the office is assisting county commissioners in addressing the unstable health care conditions. This help includes analysis and recommendations regarding the future of the local hospital, which appears to be a candidate for alternate uses.
- In Macon County the office plans to administer a countywide health analysis that will include recommendations for a comprehensive demonstration project to serve as a model for Alabama.
- In Covington County the office has assisted in recruiting a physician and providing needed assistance to the newly recruited physician. Other assistance has included finding a temporary physician so that the full-time physician can take a vacation.

Future Activities

- The Office of Rural Health is involved in coordinating a proposal with the University of Southern Alabama's Department of Family Practice to place medical residents in public health practice.
- The Office of Rural Health will serve as coordinator of a University of Southern Alabama-proposed project to establish Health Education Training Centers in thirty-three Health Manpower Shortage Area counties in Alabama. The proposed program would use educational incentives to attract and retain health care personnel in scarce areas as well as provide medical services in areas where they are so desperately needed.
- The office currently is involved in applying for grant monies from private and federal sources for technical and nonfinancial assistance.

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Arizona: Office of Rural Health

Statistics

Established	**1982**
Staff size:	Forty
Budget:	$3.0 million
Organizational Base:	University of Arizona, College of Medicine.

Background

The Rural Health Office (RHO) at the University of Arizona was established by legislative mandate in 1982 to serve as the officially designated rural health advocacy and coordinating arm of state government. The office works closely with the Arizona Department of Human Services and other entities involved in primary care, promoting quality health care through innovation and change. Serving as a state resource, its main focus is to promote collaboration at the community level.

Current Activities

The rural health office conducts the following activities:

- Coordinates National Health Service Corps/primary care activities as part of a Primary Care Cooperative Agreement with the federal government;
- Serves as the designated program office for the Arizona Area Health Education Center serving all fifteen counties;
- Operates a statewide health-provider match program;
- Provides clinical services to small communities in southern Arizona through the use of a mobile primary care unit; and
- Provides physician placement services to a variety of health organizations throughout the state.

The newest program area of the RHO is the Southwest Border Rural Health Research Center. Funded primarily by the federal Office of Rural Health Policy, the center's fundamental mission is to increase access to health services and improve the health status of residents of the southwest border region. Major emphasis is being placed on primary health care delivery, health manpower distribution, financing mechanisms, and barriers to health care utilization.

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Arkansas: Office of Rural Health

Statistics

Established:	**1987**
Staff size:	Forty-two persons apportioned among the three offices
Budget:	$2.8 million
Organizational Base:	Department of Health

Background

In 1979, the Arkansas Department of Health established an Office of Rural Health to aid the state in fostering strong health services systems and personnel in its rural communities. In 1985, the office was relocated to the Health Planning Office of the state's Health Services Commission. In 1987, the office was again placed in the health department and assumed a new name-Office of Primary Care. This move was made in conjunction with the office being awarded a National Health Service Corps Cooperative Agreement. The Office of Primary Care is one of three offices located within the Section of Health Facilities Services and Systems. (The Office of Emergency Medical Services and the Division of Health Facilities are the other two.)

The section is the primary focus for rural health systems initiatives, needs assessments, planning, technical assistance, and policy development for the state. It is funded through a variety of mechanisms, including state and federal monies, grants, and agreements. The three offices work together in supporting community-based health care initiatives yet work independently in their main areas of focus. As the state is predominantly rural, all three offices conduct activities germane to rural health issues, though the Office of Primary Care has become the lead office for many such issues.

Current Activities

The Office of Primary Care implements activities in three areas: manpower development, technical assistance, and resource coordination.

In the area of manpower development, the office:

- Operates the Primary Care Manpower Clearinghouse;
- Aids in the designation/redesignation of both Health Manpower Shortage Areas and Medically Underserved Areas;
- Assists in the placement of National Health Service Corps members;
- Assists in the recruitment and retention of health personnel in Medically Underserved Areas; and
- Works on the development of health manpower data systems.

The office provides technical assistance in the following areas:

- Community development for primary care resources;
- Community Health Center site/grant development;
- Clearinghouse for the Rural Medical Clinic Revolving Fund;
- Primary care resource needs assessment; and
- Data development for health resources.

The office fosters coordination with:

- Medical providers;
- Community health clinics;
- Interagency primary care resources; and

- Interdepartmental primary care resources.

Future Activities

Future plans for the **office** include the continuation and expansion of current activities. For instance, the office began a primary care provider survey in 1987 that has become an annual activity. In addition to ascertaining who is practicing what, the office now is asking policy-oriented questions such as whether physicians are Medicaid providers or whether they practice obstetrics. The office anticipates that the growing knowledge base will aid in future planning. Additionally, the office anticipates evolving into the official Arkansas Office of Rural Health provided federal funds are made available for that purpose.

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California: Rural and Community Health Division

Statistics

Established: ***1978***

***Staff* size:** Eighty

Budget: $1.5 billion

Organizational Base: Department of Health Services

Background

Based on legislation passed in July 1978, the Department of Health Services (DHS) established the Rural Health Division by combining the contract counties, which provide for public health services to small rural counties, the Indian health programs, rural health programs, farmworker health services; and rural hospital programs. The basic responsibility of the division was to provide funding to primary care clinics in California.

The Rural and Community Health Division was established in 1986 as a result of a major reorganization within the DHS that combined three major programs: the Rural Health Division, Office of County Health Services, and Center for Health Statistics Program. In the same year, various pieces of rural health legislation were combined under a single statute that requires the DHS, through the Rural and Community Health Department, to prepare a statewide health plan and maintain existing primary care clinic programs. The division is composed of three branches and a special projects unit. The objectives of the Rural and Community Health Division include providing public health services and ambulatory health care services to those primarily in rural areas who otherwise would have little or no access to such services, and providing financial support to local health agencies, county hospitals and facilities, and indigent care programs.

Current Activities

Among the Rural and Community Health Division's many and varied activities are the following:

- Providing financial and technical assistance to primary care and farmworker clinics;
- Reimbursing primary care clinics that provide health care services to eligible recipients under the Immigration Reform and Control Act;

- Providing direct public health nursing and environmental health services to counties with a population of less than 40,000;
- Providing financial and technical assistance to clinics serving Native Americans in order to improve their health status through medical and dental care services; and
- Identifying causes and developing solutions to the problems threatening the survival of rural hospitals.

Future Activities

The Rural and Community Health Division does not envision any drastic alteration of its current services and anticipates fulfilling its mandate for the foreseeable future.

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Georgia: Office of Rural Health

Statistics

Established: September 1977
February 1989 (re-established)

Staff Size: One

Budget: No specific budget-all in-kind contributions

Organizational Base: Department of Human Resources, Division of Primary Care

Background

In September 1977 the director of the Division of Public Health established the Rural Health/Primary Health Care Section (PHCS) as a new section within the Division of Public Health. The initial funding for this section was directed toward rural health and primary care. During the 1980s, the rural health portion of the designation was eliminated when the focus shifted toward primary care for all people regardless of their location.

In mid-1988, the Governor appointed a task force to study and report on rural hospitals. That report called for the development of an office of rural health and recommended that it be placed within an existing state system. In early 1989, the PHCS presented a plan and a budget for redevelopment of the Office of Rural Health. In late 1989, the Governor appointed an Access to Health Care Commission and asked the commission to specifically address the need for and placement of the Office of Rural Health.

Current Activities

The current focus for this developing office is to raise awareness for the rural health care dilemma and to build a network of concerned, interested, and knowledgeable parties to assist with repairing and/or rebuilding the rural health care delivery system.

In addition to the initial organizational activities, the Office of Rural Health is active in:

- Planning for delivery and financing of services for migrant and seasonal farmworkers;

- Providing consultation and technical assistance to rural health departments, primary health care providers, and rural hospitals. (When funding is available more technical assistance and planning expertise to communities and hospitals will be made available.);
- Providing and recruitment planning and assistance for rural communities with regard to physicians, nurses, nurse practitioners, nurse-midwives, and/or physician assistants. (These activities include working with and encouraging training programs for physicians and mid-level practitioners.);
- Providing community-based training and community assistance in applying for grants to assist with planning or implementing healt h care services in rural areas. For example, the office staff will assist communities with planning for Rural Health Clinic Act Designation and Health Manpower Shortage Area designation; and
- Providing continuing education for nurses and nurse practitioners, physician assistants, and nurse-midwives.

Future Activities

The activities listed above are only a few in which the office currently is involved. Plans include assisting with rural health care management needs, and conducting research on a variety of rural health issues.

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Idaho: Rural Health Education Center

Statistics

Established: 1987

Staff size: 5.75 (full-time equivalent)

Budget: $450,000

Organizational Base: University of Washington's Area Health Education Center Office

Background

The University of Washington School of Medicine's Area Health Education Center (AHEC) established the Idaho Rural Health Education Center (RHEC) in 1987. Its mission was to improve the quality, access, and delivery of rural health care in the state. In order to accomplish this task, the RHEC carries out the functions of a state office of rural health-recruiting health officials, sponsoring education programs, and working with rural communities-though it has no state mandate and receives no state funds. In the absence of a government mandate, the RHEC operates under the guidance of a nineteen-member board of directors. Funding is derived from the University of Washington AHEC Project, the Northwest Area Foundation, and fees generated from recruitment and education programs.

Current Activities

Short-Term Activities

- Provides health education to rural health professionals, especially in the area of AIDS education;
- Recruits health professionals to rural areas;

- Provides for the development of rural of health services; and
- Provides market surveys for five rural hospital communities and assists in strategic planning.

Long-Term Activities

The RHEC considers its long-term activities to be an extension of its short-term activities, though in the long term it wants to enlist state support for an office of rural health.

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Illinois: Center for Rural Health

Statistics

Established: 1989

Staff size: Eleven

Budget: ***$5.0*** million (fiscal 1991 projected)

Organizational Base: Department of Public Health

Background

The Illinois Center for Rural Health fulfills its primary mandate-recruitment and retention of health professionals-through the allocation of close to 90 percent of its budget to grants and scholarships. The center administers a medical student scholarship program similar to the National Health Service Corps. The office also funds the Physician Loan Repayment Program. That program, which began in January 1990, identifies family practice residents with outstanding student loans and offers to repay the debt if the resident agrees to practice in a rural setting in Illinois.

The center also staffs the Illinois Rural Health Association (IRHA). The 329-member IRHA is a nonprofit organization that advocates legislation and additional funding for issues and activities germane to rural health.

Current Activities

The Illinois Center for Rural Health's goals and activities are constantly expanding. The center considers its most important activity to be the provision of technical assistance allowing local communities to identify their health care needs and to achieve a system to meet those needs, Specific activities include:

- Providing aid to rural hospitals to ensure their survival. Such assistance includes aiding in both implementation of swing bed programs and the eligibility process, to be designated as sole community hospital. The center's assistance program extends to helpingwith a planned closure for those hospitals that need to discontinue operations;
- Prompting and aiding in the implementation of the Rural Health Clinic Act and the Rural Health Care Transition Grants Program;
- Assisting leaders in rural communities define their specific health care needs and identify strategies to fulfill those needs. Such strategies include aiding in the development of health department services in uncovered

rural counties and encouraging existing and new health departments to expand their services to include primary care;

- Encouraging the growth of organized and integrated health services with local providers and promoting the use of physician assistants and nurse practitioners, with appropriate back-up, as primary care providers in rural areas;
- Collecting data and requesting designation of Medically Underserved Areas and Health Manpower Shortage Areas; and
- Administering scholarship programs for physicians, nurses, mid-level practitioners, and dentists.

Future Activities

Future plans include the development of provider recruitment programs and further coordination of existing programs.

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Iowa: Office of Rural Health

Statistics

Established:	1989
Staff size:	Four
Budget:	$187,000
Organizational Base:	***Office*** of Health Planning, Iowa Department of Public Health

Background

The Iowa Legislative Task Force on Rural Health was formed in 1987 to uncover and examine differences between health services in urban and rural Iowa. The task force, having discovered significant differences particularly in the area of physician recruitment (167 communities are seeking physicians in Iowa) and access, recommended the creation of a state office of rural health. The Governor and legislature responded favorably to the recommendation and the Office of Rural Health was established in 1989 with a mission to coordinate between existing players and interest groups to ensure access to quality health care for Iowa's rural communities.

Current Activities

Short- Term Activities

- Introduce young people to health professions in a cooperative program with the Department of Economic Development;
- Administer grant programs to sponsor graduate nursing programs for Iowa nurses and to support hospital-based agricultural health and safety programs; and
- Facilitate working arrangements between the Iowa Department of Employment Services and the Office of Rural Health.

Long- Term Activities

The goal and focus of the office **will** not change over the long term. The office will continue to strengthen the current system.

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Kansas: Office of Rural Health

Statistics

Established: *1989*

Staff size: Three

Budget: $65,000

Organizational Base: Department of Health and Environment

Background

In 1988, the Governor's Task Force on the Future of Rural Communities outlined five essential elements without which a rural community could not exist. One such element was health care. In its report to the legislature, the task force recommended the creation of an office of rural health, with a mission to ensure the delivery of quality health services in rural Kansas. The legislature acted favorably, and the Kansas Office of Rural Health was established in 1989 within the Department of Health and Environment.

Current Activities

In order to fulfill its mission, the office conducts analyses of policies affecting health services in rural areas; provides technical assistance to communities to foster the development, enhancement, or salvation of their health systems; and conducts community educational activities focusing on changes in health delivery systems.

Some of the office's activities include:

- Coordinating the Governor's Invitational Conference on Rural Health Policy for the 90s;
- Initiating regular interagency collaboration with the Departments of Commerce, Aging, and Social and Rehabilitation Services;
- Initiating community education projects with teams of community leaders in two test counties; and
- Providing consultation and technical assistance to persons and communities seeking federal designation as a Health Manpower Shortage Area.

Future Activities

- Developing a pilot project for a regional public health services system in one rural area in need of shared services in order to provide a full complement of public health services;
- Developing and distributing a community continuum of care assessment tool;
- Developing a rural health data system on both manpower and service gaps; and
- Seeking funding for studies regarding clinically effective uses for electronic communications systems.

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Mississippi: Office of Rural Health

Statistics

Established: 1990

Staff Size: Three

Budget: $234,000 *(fiscal* 1991)

Organizational Base: Department of Health

Background ***The*** Mississippi legislature authorized the Mississippi State Board of Health to establish an office of rural health in the 1990 regular session. The Office of Primary Care Liaison moved into the Bureau of Health Resources on October 1, 1990, to broaden its responsibility as a lead agency for rural health issues.

By statute, the Office of Rural Health will collect and evaluate data on rural health conditions and needs; engage in policy analysis, policy development, and economic impact studies with regard to rural health issues; develop and implement plans, and provide technical assistance to enable community health systems to respond to various changes in their circumstances; plan and assist in professional recruitment and retention of medical professionals and assistants; and establish information clearinghouses to improve access to and sharing of rural health care information.

Current Activities The Office of Primary Care Liaison has ongoing programs for health manpower recruitment and retention, as well as for the provision of technical assistance and the dissemination of information. These tasks will be expanded beyond the focus of community health centers and Health Manpower Shortage Areas to include all rural areas of Mississippi. The rural nature of the state makes this an important program expansion.

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Montana: Office of Rural Health

Statistics

Established: 1987

Staff Size: Three full-time employees, shared with the Montana Area Health Education Center (AHEC).

Budget: Not Available

Organizational Base: Under the "umbrella" of the Montana AHEC

Background ***The*** Montana Office of Rural Health (MORH) was developed in 1987 as a response to the Community Health Services Development Program. The Community Health Services Development Program is an extension of a prior initiative of the Department of Family Medicine at the University of Washington. It was a joint project of the regional AI-IEC, the University of Washington School of Medicine, and the Montana AHEC.

Although both the AHEC and the Office of Rural Health are located on the campus of Montana State University, there is no administrative affiliation with the university. The staff of the MORH consists of a director, program coordinator, and secretary. The director plays a dual role, serving as director of both the Office of Rural Health and the AHEC. The other staff members divide their time between the two offices.

Current Activities The activities of the Montana Office of Rural Health have focused primarily on the Community Health Services Development Program. The purpose of the program is to strengthen rural health services in Montana. The program works directly with communities to demonstrate effective methods for improving rural health care systems.

Some of the services provided include:

- Community needs structure;
- Management reviews;
- Analysis of organization structure;
- Market surveys;
- Financial studies;
- Long-term strategic planning; and
- Restructuring of local health systems.

The Community Health Services Development Program has been implemented in six rural communities.

Future Activities There has been a great deal of discussion among the Hospital Association, Montana AHEC, and the Montana Department of Health and Environmental Sciences about the development of a formal office of rural health. While no decision has been made as to the location of an official office, the Governor has shown a strong interest in locating the office outside the state health department.

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Nebraska: Office of Rural Health

Statistics

Established: 1990

Staff Size: Three full-time employees

Budget: *$54,185* (fiscal 1990-91)

Organizational Base: Department of Health

Background Although the office did not receive official sanction until April 1990, activities in rural health date back to 1977. The Office of Rural Health was administratively established within the Department of Health in 1988 and was funded through both a cooperative agreement with the Health Resources and Services Administration (HRSA) and state appropriations. However, an April 1990 law created the Nebraska Office of Rural Health with state funding of $54,185 for fiscal 1990-91.

Current Activities

- The Nebraska Medical Student Loan Program was established in 1979. In addition to processing the loans, the office conducts follow-up activities with the loan recipients now practicing in Nebraska Health Manpower Shortage Areas (twenty-eight).
- The office assists Nebraska applicants for Rural Health Transition Grants.
- The office works with area medical schools to attract students for placement in shortage areas.
- The office aids in community and regional planning.

In addition to the activities already mentioned, the office staffs a Rural Health Manpower Commission. Staff are responsible for conducting meetings, reviewing shortage areas, distributing medical student loans, and developing rural health policy. Recently, the office played a major role in the first Governor's Rural Health Conference, which was followed by seven public forums with more than 500 participants from across the state.

Future Activities ***The office*** is planning to produce a quarterly newsletter. The office also is in the process of developing alternatives to the Medical Student Loan Program. Some of the options being explored include interest-free loans, elimination of payback for those serving in medical shortage areas, and tax deductions for medical personnel serving in shortage areas. A nurse scholarship program also is being developed. Rules and regulations will be established for the selection of thirty awards and thirty alternates.

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Nevada: Office of Rural Health

Statistics

Established: 1977

Staff size: Four

Budget: $415,000 (fiscal 1991)

Organizational Base: University of Nevada School of Medicine

Background ***The Office*** of Rural Health was established by legislative mandate in 1977. Set within the University of Nevada School of Medicine, the office operates

to improve the health of Nevadans through positive changes and to strengthen health care delivery to underserved populations and communities. The office remains a line item in the school's budget that is submitted to the legislature every two years and receives additional funding through contractual arrangements with federal and state agencies.

Current Activities

The office's activities vary from year to year as different grant programs are initiated and concluded. For instance, the office's primary focus in 1987 was an initiative to provide assistance to rural hospitals. The office's efforts in this area resulted in a four-year award from the Robert Wood Johnson Foundation to support the Nevada Rural Hospital Project.

General office goals and services fall within seven areas outlined below:

- Aid to rural communities to assess their health care needs and resources and to assist them in their design and acquisition;
- Technical aid to community clinics, hospitals, agencies, and individuals relative to health services, manpower, and resource development;
- Recruitment and retention strategies for health care manpower in both rural and underserved urban communities;
- Coordination with the state of Nevada to designate underserved and manpower shortage areas;
- Advocacy for rural development and coordination with health care programs and facilities;
- Exposure and education regarding rural health systems to potential practitioners, business enterprises, and social services agencies; and
- Community development activities to facilitate the strengthening of the rural health system within communities, counties, and the state.

Since its inception, the office has established and maintained several programs including the following:

- Nevada Health Service Corps (a loan repayment program offering scholarships for nurse practitioners, nurse-midwives, and physician assistants);
- Family Practice Demonstration Project that serves as a model for recruitment of rural practitioners;
- Obstetrics Demonstration Project that is designed to support and maintain obstetrical services in rural communities; and
- Clearinghouse, which performs recruitment and retention activities.

Future Activities

Plans include beginning a Physician Assistant Training Program in conjunction with the School of Medicine.

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New Mexico: Primary Care Section

Statistics

Established:	1981
Staff size:	Four
Budget:	$1.2 million
Organizational Base:	Department of Health, Primary Care Section

Background

As a response to the 1979 Governor's Conference on Rural Health, the New Mexico legislature passed the Rural Primary Health Care Act, establishing the Primary Care Section within the Emergency Medical Service Bureau of the state's health department. The section was established to recruit and retain health care personnel and assist in the provision of primary health care services in underserved areas of the state. In as much as only one New Mexico county has been classified as urban, primary care issues and rural health services are indistinguishable. The Primary Care Section works closely with the New Mexico Primary Care Association and New Mexico Health Resources in creating and administering programs to improve health care delivery in rural areas.

Current Activities

The office's current activities include:

- Planning and administering a health personnel development program;
- Designating Health Manpower Shortages Areas and Medically Underserved Areas;
- Empowering local communities to identify and solve their health problems; and
- Providing technical and financial assistance to localities.

Future Activities

Future activities include an expansion of the Primary Care Section to an office of rural health if federal funds become available. The section also intends to establish a referral system for the state's hospital system.

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North Carolina: Office of Rural Health and Resource Development

Statistics

Established:	***1973***
Staff Size:	Twenty-five
Budget:	$2,082,617
Organizational Base:	Department of Human Resources

Background

The North Carolina Office of Rural Health Services (ORHS) was established in 1973 to provide readily available and accessible primary care services to rural residents of North Carolina. The establishment of the

ORHS was one component of a two-pronged approach undertaken by the state legislature to address the crisis in the rural health services area. (The second component was an Area Health Education Center initiative.) Legislative attention was focused on rural health during a time when the number of medical school graduates opting for residencies in primary care was dwindling as more future doctors chose to specialize. The general practitioners who historically cared for the state's rural populations were growing older, while the majority of the state's younger family practitioners were opting to establish practices in the state's urban centers. Despite offering incentives, rural communities were unsuccessful in their attempt to lure doctors to their areas.

In the absence of general practitioners, the first approach the ORHS explored was to use mid-level physician extenders, based in nonprofit clinics established with state and community funds (a 5 to 1 match was required). In later years, the office established the Physician Location Assistance Program, which drew from both national residency programs and the Area Health Education Center, and brought in new recruits to provide physician backup. More than 850 doctors have been recruited through this program. In 1985, the office's name first changed to the Office of Rural Health Services and Resources Development and, when it was given the additional task of providing technical assistance to hospitals, it became the State Health Planning Agency. In 1990, when the rural health problem again reached critical levels, the office was administratively relocated to the Office of the Secretary, Department of Human Resources, and its health planning duties were reassigned.

Current Activities

Short-Tenn Activities

- Create incentive programs to attract available primary care physicians to North Carolina.

Long- Term Activities

- Work with the federal government to strengthen the federal loan repayment program;
- Work to reauthorize the Public Health Service Corps; and
- Work with North Carolina medical schools to increase the number of primary care physicians and enhance their skills.

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North Dakota: Center for Rural Health

Statistics

Established:	1980
Staff size:	Eighteen
Budget:	$1.1 million
Organizational Base:	University of North Dakota School of Medicine

Background

The state's Office of Rural Health was established in 1980 within the University of North Dakota School of Medicine. In 1986 the office received a substantial grant from the Bush Foundation enabling it to expand its organization and enhance its services. While the new Center for Rural Health maintained its state rural health office activities, it took on the added responsibility of serving as the home of the North Dakota Area Health Education Center and became one of five federally funded Rural Health Research Centers. The center is subdivided into three divisions: Division of Rural Health Services, Division of Education and Demonstration, and the University of North Dakota Rural Health Research Center.

Current Activities

The Division of Rural Health Services conducts activities in a variety of areas such as providing technical assistance to rural hospitals and clinics; designating Health Manpower Shortage Areas; and providing networking services among university medical internship programs and rural hospitals. The office also provides recruitment and retention services, which have recruited sixty-two physicians to serve in the state's rural and frontier communities.

The Division of Education and Demonstration administers the following programs:

- Affordable Rural Coalition for Health (ARCH) that uses community development techniques to improve local health care delivery;
- Leadership Education and Development Program that combines academic leadership training, private sector assistance, and economic development matching funds to local rural leadership teams; and
- Rural Health Education Outreach Project that aids in the development of two-way interactive television classrooms throughout the state.

The University of North Dakota Rural Health Research Center (UNDRHRC) is involved in various policy-relevant research projects. The UNDRHRC has established the National Rural Health Policy Network and has initiated a six-state rural nursing study.

Future Activities

The Division of Rural Health Services anticipates moving away from past activities through the initiation of a catalyst role empowering local communities to identify and solve their rural health problems.

The Division of Education and Demonstration anticipates continuing the administration of current programs, and the initiation and administration of other programs and projects aiding North Dakota's rural communities.

UNDRHRC anticipates a continuation of its activities focusing on contemporary rural health services.

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Oregon: Office of Rural Health

Statistics

Established:	**1979**
Staff Size:	***2.5*** full-time employees
Budget:	$284,500
Organizational Base:	Oregon Health Sciences University

Background

In existence since 1979, the Oregon Office of Rural Health was originally located in the State Health Planning and Development Agency (SHPDA) for the purpose of administering a federal-state cooperative agreement to serve Health Manpower Shortage Areas. A transformation of the office began in 1987 when several health statutes were repealed. At the same time, the legislature established an Office of Health Policy that was assigned a portion of SHPDA's functions.

In 1989, Senate Bill 438 was passed, relocating the Office of Rural Health (ORH) from the Office of Health Policy to the Oregon Health Sciences University (OHSU). Now a component of the state system of higher education, ORH is funded exclusively through the OHSU budget, which consists primarily of general revenue funds.

The office's activities have far exceeded those originally intended. In addition to assisting with the determination of manpower shortage areas and placement of National Health Service Corps scholars, the office has served as a focal point for the development of rural health policy positions, both at the state and national levels.

Oregon's Office of Rural Health also has served as a source of technical support for rural providers, especially small, isolated rural clinics staffed primarily by mid-level practitioners. More than fifty small rural clinics have benefited from the agency's counsel in the past decade, including twenty-six separate facilities that have received more than $240,000 in grant funds from ORH.

Current Activities

The Omnibus Rural Health Bill outlines the following program responsibilities:

- Establishing a system whereby rural hospitals can be classified according to their need for assistance and services, including cost-based medical reimbursement and eligibility determination for contracted technical assistance to restructure rural hospital services;
- Administering a state income tax credit of up to $5,000 for physicians, nurse practitioners, and physician assistants who practice in rural areas; and
- Contracting with a professional physician recruitment agency to place physicians in rural areas experiencing medical manpower shortages.

In addition, the office currently is involved in a number of other activities, including:

- Advising the Governor-appointed Rural Health Coordinating Council, which cosponsors an annual Rural Health Conference;
- Providing information on rural health services and policies to a diverse group of constituents through a clearinghouse; and
- Serving as an advocate for small and rural clinics.

Contact Person

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South Dakota: Office of Rural Health

Statistics

Established:	**1989**
Staff size:	Five
Budget:	$150,000
Organizational Base:	Dual location-South Dakota School of Medicine and South Dakota Department of Health

Background

The need to improve declining health care delivery in rural South Dakota provided the impetus for the creation of the South Dakota Office of Rural Health (ORH). The task force charged with establishing the office and finding its home concluded that South Dakota had two agencies with significant resources already in place. The University of South Dakota School of Medicine had an ongoing relationship with physicians and health professionals statewide, and the Department of Health performed physician recruitment and placement activities.

The task force recommended the formation of a single office of rural health, combining the resources and expertise of both agencies to improve the delivery of health services in rural areas of South Dakota through service, education, research, and policy analysis. As a result, the Office of Rural Health is a joint effort of the Department of Health and the South Dakota School of Medicine and has offices in both locales. It is assisted by a thirteen-member ORH Advisory Council.

Current Activities

The Office of Rural Health conducts activities in the following areas:

- Recruitment and retention of physicians and mid-level practitioners;
- Community assessments and consultation;
- Shortage designation;
- Rural Health Clinics Act;
- Rural health conference;
- Opportunities Awareness Project;
- Rural student recruitment program;
- State physician reimbursement program;
- Tuition waiver program;
- Freshman rural health seminar; and
- Technical assistance.

Future Activities

The Governor is working with ORH in developing a statewide rural health strategy for the 1990s.

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Texas: Center for Rural Health Initiatives

Statistics

Established: ***1990***

Staff size: Four

Budget: ***262,500*** (fiscal 1992)

Organizational Base: Texas Health Department.

Background ***The*** Texas Legislature established the Center for Rural Health Initiatives to "serve as the primary state resource in coordinating, planning, and advocating for continued access to rural health services in Texas." The center began operating in June 1990.

The center is governed by an executive committee appointed by the Governor, Lieutenant Governor, and Speaker of the House of Representatives. An advisory committee of representatives of eight state agencies assists the center and provides agency support.

Current Activities The center has a broad array of duties that it seeks to accomplish cooperatively with state agencies, associations, rural communities, and interested organizations. The initial priority of the center is the full implementation of the Omnibus Health Care Rescue Act of 1989 and other state rural health legislation.

Future Activities Future activities include a clearinghouse on rural health issues, policy analysis and research, education and advocacy, and services for rural communities. Additionally, the center will make a report to the next session of the Texas Legislature with findings and recommendations on rural health care in Texas.

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Utah: Office of Local and Rural Health Systems

Statistics

Established: 1981

Staff Size: ***Two*** full time, one one-third time

Budget: ***$90,000***

Organizational Base: Department of Health, Office of the Executive Director

Background

The Office of Local and Rural Health Systems (OLRHS) is the lead unit within the Utah Department of Health @OH) for facilitating and implementing a cooperative agreement among the DOH, the Association for Utah Community Health, and the U.S. Public Health Service. OLRHS is a member of the National Rural Health Association and participates actively with state and frontier constituency groups. OLRHS functions as a state office of rural health and as a liaison between the state health department and local health departments.

OLRHS's mission is to improve access to quality health care for the people of Utah through the strengthening of local health departments and the enhancement of health care providers' skills in rural, underserved areas. OLRHS addresses the management and service delivery needs of local health departments, community health centers, rural health care practitioners and facilities, providers of special medically underserved populations such as migrant and seasonal farmworkers, the medically indigent, ethnic minorities, and the homeless.

Current Activities

Coordination and Advocacy

- Represents the interests of local health departments and providers of the underserved or disadvantaged in ongoing DOH activities;
- Serves as a center for information about these special populations and their health care providers;
- Provides staff and leadership to the DOH's Rural Health Advisory Committee; and
- Solicits and collects public reactions to DOH initiatives, obtaining input on DOH policies and plans.

Consultation, Technical Assistance, and Training

- Provides technical aid to community health centers and statewide migrant health programs, including board and staff training, marketing, and automating office systems;
- Aids the Utah Department of Commerce, Division of Occupational and Professional Licensing, in establishing criteria for branch (rural) pharmacies and in reviewing new applications and renewing existing applications; and
- Aids several hospitals with their application for Rural Health Care Transition Grants Program funds.

Health Manpower Recruitment and Retention

- Assists Utah rural and underserved primary health care providers nationwide;
- Updates names of providers and disseminates them through activities such as direct mail campaigns, journal advertisements, convention displays, and U.S. Public Health Service referrals. (Since October 1987 nearly 600 leads have been generated.);
- Helped draft and obtain passage and funding ($325,000) of a rural physician education loan repayment program;
- Helped draft and obtain passage of a rural physician scholarship program; and
- Filled twenty-six health manpower vacancies.

Community Health Nursing

- Acts as a focal point for nursing with DOH that includes developing, implementing, monitoring, and evaluating public health nursing care; and provides consultation and technical assistance to local health departments, DOH, and external nursing groups.
- Completed a grant for $77,000 from the Family Health Planning (FHP) Foundation, in cooperation with the Association for Utah Community Health. The funds were shared by the frontier community health centers for geriatric outreach and services.

Contact Person

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Eastern Washington: Office of Rural Health

Statistics

Established: ***1987***

Staff size: Eight

Budget: ***$200400***

Organizational Base: Washington State University

Background

Activities of the Eastern Washington Area Health Education Center (AHEC) provided the impetus for the establishment of the Eastern Washington Office of Rural Health (EWORH). EWORH helps rural communities develop viable and well-managed health care systems by offering resources and professional guidance to assist these communities in designing services to fit the needs of their residents.

While EWORH is physically located at Washington State University (WSU), it is supported cooperatively by both WSU and the University of Washington. In addition to the in-kind support of these universities, the office receives funding from the U.S. Public Health Service, the Northwest Areas Foundation, and communities receiving assistance from the office.

Current Activities

The Office of Rural Health has taken on a variety of activities that focus on helping communities assess their needs and develop initiatives to retain and enhance health care services. For instance, the office links communities with experts in areas such as:

- Strategic planning;
- Governance and management of health care programs;
- Financial analysis and planning;
- Scope of services analysis; and
- Market analysis.

In addition to serving the overall community, the office:

- Collaborates with other organizations to sponsor the annual Northwest Rural Health Conference;
- Leads in the creation and support of the Washington State Rural Health Association; and
- Co-administers a graduate program at Washington State University focused, in part, on health care administration in rural areas.

Future Activities

EWORH's main focus for the next several years will be on the establishment of a statewide office of rural health within the Department of Health.

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The University of Wisconsin: Office of Rural Health

Statistics

Established: 1975

Staff size: Five

Budget: $260,000 (fiscal 1991)

Organizational Base: University of Wisconsin, Center for Health Sciences

Background

The Wisconsin Office of Rural Health was established in 1975 to help develop rural health training sites for the health professions schools in the Center for Health Sciences. As the office evolved, its activities branched out in many different directions. Currently, the office's mandate is to foster the development of programs germane to rural health; foster rural health community development; and continue to conduct policy analysis. In addition, a major responsibility of the office is to conduct physician recruitment and retention activities, which have placed more than 200 physicians to date.

Current Activities

- The office serves as a statewide resource for physician practice development; provides technical assistance to communities; and administers the Physician Loan Assistance Program.

Future Activities

- Draft and implement a statewide Rural Health Clinic bill modeled after the Community Health Centers;
- Promote nurse midwifery in both urban and rural areas with general practitioner backup;
- Expand the Physician Loan Assistance Program to place a greater emphasis on minorities; and
- Work toward the reauthorization of the National Health Service Corps.

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North Central Wisconsin: Office of Rural Health

Statistics

Established:	1989
Staff Size:	TWO
Budget:	$100,000
Organizational Base:	Private nonprofit

Background

The North Central Wisconsin Office of Rural Health (NCWORH) was established in March 1989 as a program of the Wausau Health Foundation. NCWORH is an extension of earlier regionally oriented activities of the foundation that included providing support for emergency medical technician training and scholarships for nursing education. NCWORH operates in collaboration with the University of Wisconsin Office of Rural Health in Madison, Wisconsin, through joint planning and cooperative ventures.

Current Activities

The mission of the NCWORH is to assist community-based initiatives in health care, coordinate the development of regional positions and consensus on health policy, and provide limited seed money for health-related community projects. The major activity areas of the office are:

- Rural health data development;
- Educational services;
- Recruitment and retention services; and
- Information clearinghouse services.

Other activities during its first fourteen months of operation have included:

- Aid in planning, hosting, and conducting the health component of the Wisconsin Rural Leadership Program;
- Aid in the planning for an Area Health Education Center grant application, and in local education and promotion of the AHEC concept; and
- Aid in the development of a Rural Health Care Transition Grant Program consortium proposal submitted by six north central Wisconsin rural hospitals.

Future Activities

Future activities will focus on additional program development services, especially regarding telecommunications capacity; development of the rural health database; and development of educational and clearinghouse services.

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4. Compendium of State Rural Health Initiatives

MAINTAINING EXISTING HEALTH CARE FACILITIES

California

Program

California's Alternative Rural Hospital Model was designed for the same purpose as the Medical Assistance Facility (MAF); however, it was designed with even greater flexibility in mind. This alternative rural hospital model permits services to be added and subtracted from a set of required services in modular fashion. A state technical advisory committee is considering adoption of a ninety-six hour or longer inpatient stay limit.

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Colorado

Program

The state of Colorado developed a new licensure category for rural providers called Community Clinic/Emergency Center(CCEC). CCECs provide only emergency and outpatient services, but they must have a written affiliation with a nearby general hospital to coordinate patient referral services needs. The CCECs can have a maximum of six beds to stabilize patients for up to seventy-two hours. The facilities must have twenty-four hour skilled nursing coverage available on site, with a physician available by phone and within fifteen minutes travel time.

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Cross Reference

Improving Emergency Medical Care

Florida

Program

Florida laws give special treatment to twenty-seven of Florida's sixty-two rural acute care hospitals. These twenty-seven hospitals have emergency rooms, eighty-five or fewer beds, and are either a sole provider in a county with a population density of no greater than 100 persons per square mile; or located in a county with a population density no greater than 100 persons per square mile and at least thirty minutes travel time from another acute facility within the same county; or supported by a hospital tax district or subdistrict boundaries of which encompass a population of 100 persons or less per square mile.

In an effort to provide the best situation for survival, these hospitals are eligible for several exemptions and special considerations. For example these hospitals are: eligible for Medicaid swing bed reimbursement; exempt from certificate of need review for home health, hospital, and swing bed services for up to half of their acute care beds;

exempt from Health Care Cost Containment Board budget review; exempt from numerous assessments. They also receive preference for Florida's Health Care Professional Loan Repayment Program.

Contact

Richard Polangin
Health Services and Facilities Consultant
HRS, PDRHP
2727 Mahan Drive
Tallahassee, Florida 32308
(904) 488-8396

Florida

Program

Florida established a new category with requirements similar to the facility requirements of the Medical Assistance Facility (MAF). Emergency Care Hospitals (ECHs) must be located in counties with less than 101 persons per square mile and be either the sole provider in that county or at least thirty minutes travel time from any other similar hospital. Florida's ECH laws also vary from the MAF laws in that ECHs retain their licenses as hospitals, giving them additional flexibility in terms of the services they can provide.

Contact

Richard Polangin
Health Services and Facilities Consultant
HRS, PDRHP
2727 Mahan Drive
Tallahassee, Florida 32308
(904) 488-8396

Cross ***Reference***

Improving Emergency Medical Care

Iowa

Program

In January 1989, through state legislation, the Community and Rural Development Loan Program (CORDLAP) made $3.2 million available to provide grants and low-interest loans to communities for traditional and nontraditional infrastructures. Nontraditional infrastructures can include such health-related services as medical decision support systems and emergency medical services. The Iowa Department of Economic Development is responsible for reviewing the applications and administering the program. Applications are reviewed based on the following: the financial need of the applicant, cost/benefit analysis of the project, percent of matching provided, impact of the project on the community. Loans range from 0 to 5 percent and are awarded based on the availability of funds.

Contact

Cindy Liston
Field Representative
Iowa Department of Economic Development
200 East Grand Avenue
Des Moines, Iowa 503 11
(515) 281-3752

Cross ***Reference***

Providing Financial and Technical Assistance: Financial Assistance

Iowa

Program

The Iowa General Assembly appropriates $400,000 each year for a grant program to encourage stronger linkages with existing rural service providers and innovative economic development models. Eligible applicants include rural communities, rural counties, councils of government, and educational institutions. Health service providers may be part of the grant application team.

Contact

Kathy Beery
Rural Development Coordinator
Iowa Department of Economic Development
200 East Grand Avenue
Des Moines, Iowa 50309
(515) 281-7269

Cross Reference

Providing Financial and Technical Assistance: Financial Assistance

Kansas

Program

In early 1989 Chaney Municipal Hospital, a twenty-four bed acute care rural hospital, was converted to the Jane Phillip's Caney Community Health Center. The conversion maintained the provision of health care to 5,000 families of farmers, oilmen, and cattlemen in an underserved southeastern area of the state. Due to state and federal requirements, the health center does not provide emergency care. However, twenty-four hour urgent care is provided by a registered nurse. Persons with more serious injuries or those requiring a specialist are stabilized and transferred to the Jane Phillip's Episcopal Memorial Medical Center.

Contact

Susan Barrett
601 South High
P. 0. Box 321
Chaney, Kansas 66633
(316) 879-2182

Kansas

Program

In 1989 St. John's District Hospital, a thirty-four bed facility, was converted to a primary care clinic. The clinic provides physician services, urgent care, and overnight observation. Patients with more life-threatening illnesses such as severe trauma, burns, and heart attacks are transported to St. Francis Regional Medical Center in Wichita. Patients at St. John's also can be transported twenty-five miles north to Great Bend to receive in-hospital primary care at Central Kansas Medical Center.

Contact

Steve McDowell
Director
Office of Rural Health
Department of Health and Environment
Division of Health
Landon State Office Building
Topeka, Kansas 66612-1290
(913) 296-1343

Montana

Program

In an effort to keep struggling hospitals from closing, Montana created a special category of health care facility Medical Assistance Facilities (MAFs). These facilities allow considerable flexibility in services provided and staff requirements. For example, MAFs are allowed to close their doors if there are no patients. However, someone, usually a registered nurse, must be on call. Frequently these facilities are located in or next to a nursing home where medical personnel can be reached quickly. Once an inpatient recipient has been admitted, the facility must remain staffed.

Medical Assistance Facilities usually are staffed by physician assistants, provided consultation with a medical doctor is available. Reimbursement through Medicaid and Medicare is not yet approved. Once approved, it is expected a number of struggling facilities will convert to Medical Assistance Facilities.

Contact

Charles Aagenes
Chief
Health Planning Bureau
Cogswell Building
Helena, Montana 59620
(406) 444-3121

New York

Program

Beginning January 1990, a swing bed demonstration project will be implemented specifically for rural hospitals. This project, modeled after the Health Care Financing Administration (HCFA) swing bed program, is designed to allow rural hospitals to use their excess bed capacity for short stay, long-term care services. Individuals must be characterized as needing Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) services. The program is under a three-year evaluation,

Contact

Dwight C. Williams
Chief, Health Planner
New York State Department of Health
Bureau of Health Facility Planning
Room 1748
Albany, New York 12237
(5 18) 4734705

North Carolina

Program

North Carolina has developed a model to assist small rural hospitals in their transition from acute care medical centers to primary care specialty care providers. This model is presently being used on a community hospital being converted from a twenty bed acute care hospital to a 100-bed medical center. The new medical center will offer nursing home care and specialty care for senior citizens as well as emergency care and augmented services for the general population.

Contact

Jim Bernstein
Director
Office of Rural Health and Resource Development
701 Barbour Drive
Raleigh, North Carolina 27603-2008
(919) 733-2040

Washington

Program

Legislation passed in 1989 created a new category of health facility licensure for rural hospitals that can no longer survive under hospital licensure. Rural health facilities licensing regulations are crafted to allow variations in the scope of general medicine, surgery, and obstetrics services. This category of health care facility will be designed to best meet the health needs of the affected community, taking into account existing health services.

Contact

Verne Gibbs
Health Planning Administration
Department of Social Health Services
Mail Stop OB-43F
Olympia, Washington 98504
(206) 491-3921

West Virginia

Program

A task force has worked with two rural hospitals on changing their missions from acute care institutions to more comprehensive rural health centers.

Contact

David K. Heydinger
Director
West Virginia Department of Health
1800 Washington Street, East
Charleston, West Virginia 25305
(304) 348-2771

Cross Reference

Providing Financial and Technical Assistance: Technical Assistance

Wyoming

Program

Wyoming has established a new licensure category designed for hospitals that can no longer operate under the acute care hospital licensure regulations. The licensure category is similar to the Medical Assistance Facility licensed by Montana, however, inpatient stays are limited to sixty hours. In addition travel time to the nearest hospital must not exceed thirty minutes.

Contact

Charlie Siminer
Program Manager of Medical Facilities
Division of Health and Medical Services
Hathaway Building - 4th Floor
Cheyenne, Wyoming 82009
(307) 777-7121

ATTRACTING HEALTH CARE PROFESSIONALS

Recruitment and Retention

Arkansas

Program

The Office of Primary Care conducts physician and other health personnel surveys periodically to assess the health care needs of Arkansas. The office aiso serves as a state clearinghouse, matching physicians with communities in need of physician services. This process also involves recruitment of physicians and placement of National Health Service Corps rotators.

Contact

Yvette Lamb
Office of Primary Care
Arkansas Department of Health
4815 West Markham Street
Little Rock, Arkansas 72205
(501) 661-2194

Cross Reference

Attracting Health Care Professionals: Medically Underserved Areas

Arkansas

Program

The Arkansas Rural Medical Practice Student Loan and Scholarship Program was designed to increase the number of physicians practicing in rural Arkansas. Any resident of Arkansas who has been accepted or enrolled in the University of Arkansas, College of Medicine is eligible to participate in the program. The program provides student loans of up to $12,000 per year. Loan forgiveness is granted for each year of debt per year of service in an Arkansas rural community.

Contact

Tom South
Financial Aid Officer
University of Arkansas for Medical Sciences
4301 West Markham Street
Little Rock, Arkansas 72205
(501) 686-5813

Cross Reference

Attracting Health Care Professionals: Education Assistance

California

Program

The California Health Services Corps makes available health personnel, physicians, dentists, and vision care providers to rural areas that are presently receiving inadequate health services.

Contact

Lawrence McCabe
Chief, Hospital and Medical Standards Program
714 P Street, OB8/550
Sacramento, California 95814
(916) 323-4704

Illinois

Program

Illinois developed a provider recruitment program to assist physicians seeking practice sites and communities needing health care providers. This effort is targeted at primary care physicians in residency programs as well as other physicians Seeking relocation. One staff member is assigned to work with the residents and medical students to establish early and continuing contact. Annually, physicians in family practice, pediatrics, internal medicine, and obstetrical residencies throughout the country are contacted through a mass mailing program. Regular advertisements in medical journals provide further awareness of practice opportunities for physicians who are considering a move. Once a decision to locate in a specific community has been made, ongoing assistance is offered to prevent development of conflicts and to make the transition to the community as smooth as possible.

Contact

Marcia Franklin
Illinois Department of Public Health
Center for Rural Health
535 West Jefferson Street
Springfield, Illinois 62671

Kentucky

Program

The Kentucky Physician Placement Service, an agency of the Department for Health Services, recruits primary care physicians for placement in predominantly rural, medically underserved counties. Recruitment is in response to community requests made primarily by local hospital administrators and physicians. There is no charge to either party for this service.

Contact

Don Coffey
Manager
Community Health Development Branch
Department for Health Services
275 East Main Street
Frankfort, Kentucky 40621
(502) 564-3386

Cross Reference

Coordinating Activities, Attracting Health Care Professionals: Medically Underserved Areas

Maine

Program

The Maine Cooperative Agreement for Primary Care Services was implemented on October 1, 1985. The cooperative agreement is a three-way agreement among the federal government, the state's primary care association, and the state of Maine. Its focus is to coordinate federal and state primary care resources; help medically underserved populations and health care providers recruit and retain physicians and other health professionals; promote the use of state primary care resources; and promote affiliations and coordination with area health providers and the state's health department, area health education centers, hospitals, and residency programs. In addition, the cooperative agreement maintains an active clearinghouse of site vacancies and health care provider files.

Contact

Sophie Glidden
Rural Health Program Manager
State of Maine
Department of Human Services
Augusta, Maine 04333
(207) 289-2716

Cross Reference

Attracting Health Care Professionals: Medically Underserved Areas, Coordinating Activities

Nebraska

Program

Nebraska's Office of Rural Health established a Physician Referral Program for rural Nebraska practice. Physicians in residency training are contacted to identify those whose backgrounds and interests make them candidates for rural Nebraska practice. A roster profiling their practice site preferences is made available to communities that are recruiting physicians.

Contact

Ray Pinkley or Tom Rauner
Office of Rural Health Physician Referral
P.O. Box 95007
Lincoln, Nebraska 68509
(402) 471-2337

Nevada

Program

The Nevada Health Services Corps, established in July 1989, provides loan repayment to health care professionals willing to serve in Medically Underserved Areas. Unlike many loan programs, thii program is targeted toward health care professionals already practicing. The program repays up to $15,000 per year toward loan responsibilities. Recipients work in a medically underserved area with loan repayment based on a year of work for a year of loan repayment, with a minimum eighteen-month commitment.

Contact

Caroline Ford
Director
Office of Rural Health
University of Nevada School of Medicine
(702) 784-4841

Cross Reference

Attracting Health Care Professionals: Medically Underserved Areas, Attracting Health Care Professionals: Education Assistance

New Mexico

Program

Through the Rural Primary Care Act, a clearinghouse was established to assist in the recruitment and retention of health professionals. This clearinghouse recruits physicians, nurses, nurse practitioners, physician assistants, and occupational and physical therapists to serve in rural and underserved areas. The clearinghouse is run by a private, nonprofit organization called New Mexico Health Resources Inc., and is funded through a budget line item under the Rural Primary Care Act.

In 1989 the state paid between $65,000 to $70,000 for these services that recruited approximately fifteen providers to rural and underserved areas.

Contact

Harvey Licht
Primary Care Section
Health and Environment Department
1190 St.Francis
Drive Santa Fe, New Mexico 87503
(505) 827-2527

Cross Reference

Attracting Health Care Professionals: Medically Underserved Areas

North Carolina

Program

Since 1975, the Office of Rural Health and Resource Development has recruited physicians through its Physician Location Assistance Program. In the year ending June 30, 1989, fifty-eight physicians were recruited to North Carolina, twenty-six of those physicians accepted positions in Health Manpower Shortage Areas. The recruitment program has emphasized full assistance to physician candidates and needy communities so that compatible matches can be found.

Contact

Torlen Wade
Assistant Director - Administration
Office of Rural Health and Resource Development
701 Barbour Drive
Raleigh, North Carolina 27603
(919) 733-2040

Oklahoma

Program

The Physician Community Match Program is a program matched by the state of Oklahoma through the Physician Manpower Training Commission and a rural Oklahoma community. The program, established to assist Oklahoma's rural communities with populations of 100,000 or less, provides financial assistance to physicians starting practice in a sponsoring community. The loan amounts vary, ranging from $20,000 to $40,008 for a minimum service obligation of two years of practice in the sponsoring community. The amounts are received in a lump sum. If the physician decides not to fulfill his/her obligation to a sponsoring community, he/she owes in lump sum the total amount plus 12 percent interest and up to a 100 percent penalty.

Contact

John Hanley
Placement Coordinator
Physician Manpower Training Commission
1000 Northeast 10th Street
P.O. Box 5355 1
Oklahoma City, Oklahoma 73152
(405) 271-5848

Cross *Reference*

Attracting Health Care Professionals: Medically Underserved Areas

Oregon

Program

Since its creation in 1979, of the Office of Rural Health has played a major role in the promotion of rural health issues. The Office of Rural Health provides guidance to rural communities regarding community organization and clinic development; conducts ongoing primary care planning for underserved areas on a statewide basis; assists rural communities in the recruitment and retention of health care providers; provides data and assists in the development of formally designated Health Manpower Shortage Areas, Medically Underserved Areas, and High Migrant Impact Areas; serves as the central agency for coordination of statewide efforts for the delivery of health care to rural areas; provides assistance to rural clinics with recruitment and retention of health care providers; and provides technical assistance to rural hospital administrators and boards of directors to identify strengths and weaknesses and assess opportunities for development.

Contact

Karen Whitaker
Office of Rural Health
Health Sciences University
3181 SW Sam Jackson Park Road, MP250
Portland, Oregon 97201-3098
(503) 4944450

Cross *Reference*

Coordinating Activities, Providing Financial and Technical Assistance: Technical Assistance

Oregon

Program — Senate Bill 438 appropriated $100,000 for the biennium ending June 30, 1991, for the Office of Rural Health to contract for professional services to recruit physicians to practice in rural areas and provide technical assistance in restructuring rural health services.

Contact — Karen Whitaker
Office of Rural Health
Health Sciences University
3181 SW Sam Jackson Park Road, MP250
Portland, Oregon 97201-3098
(503) 4944450

Cross *Reference* — Providing Financial and Technical Assistance: Financial Assistance

South Dakota

Program — The office provides a Rural Health Seminar to each freshman class at the University of South Dakota School of Medicine. Motivated physicians from rural areas are brought in to emphasize the positive aspects of rural practice and lifestyles and to combat the negative perceptions of rural practice such as grueling hours, low incomes, and the inability to practice modem medicine.

Contact — Bernie Osberg
Pierre Office
523 East Capitol
Pierre, South Dakota 57501-3182
(605) 7733361

Tennessee

Program — The state of Tennessee established a trust fund to assist communities in paying for a portion of a physician's loan responsibilities. The program is funded through unclaimed property turned over to the state. The program uses the interest from this account to pay off a portion of a doctor's loans. In the past year six doctors have been recruited under this program.

Contact — Eloise Hatmaker
536 Cordell Hall Building
Nashville, Tennessee 372475410
(615) 741-9242

Tennessee

Program — Tennessee passed the Health Access Act in 1989, which created a special account to fund a series of rural health initiatives. One of these is for professional liability insurance assistance. Under thii program, a subsidy would be provided to a physician up to the amount of the malpractice insurance premium paid. This is available for both the continuance of existing obstetrical services and the initiation of new services.

Contact — Eloise Hatmaker
536 Cordell Hall Building
Nashville, Tennessee 37247-5410
(615) 7419242

Washineton

Program — The 1989 legislature established six demonstration sites for providers to network and form an organized system of basic health services for each community. The program's focus includes, but is not limited to, the community hospital. Six communities will receive planning funds.

Contact

Verne Gibbs
Health Planning Administration
Department of Social Health Services
Mail Stop OB-43F
Olympia, Washington 98504
(206) 491-3921

Cross Reference

Providing Financial and Technical Assistance: Financial Assistance

Education Assistance

Arkansas

Program

The Arkansas Rural Medical Practice Student Loan and Scholarship Program was designed to increase the number of physicians practicing in rural Arkansas. Any resident of Arkansas who has been accepted or enrolled in the University of Arkansas College of Medicine is eligible to participate in the program. The program provides student loans up to $12,000 per year. Loan forgiveness is granted for each year of debt per year of service in an Arkansas rural community.

Contact

Tom South
Financial Aid Officer
University of Arkansas for Medical Sciences
4301 West Markham Street
Little Rock, Arkansas 72205
(501) 686-5813

Cross Reference

Attracting Health Care Professionals: Recruitment and Retention

Florida

Program

The 1985 Florida Legislature created the Medical Education Tuition Reimbursement Program to encourage qualified medical professionals to practice in underserved locations. Applicants must be physicians, nurse practitioners, and physician assistants with specialties in obstetrics/gynecology, general/family practice, internal medicine, and pediatrics, and can receive up to $10,000 per year or an amount equivalent to one-third of the total tuition and registration fees for three years. In addition, graduates must have completed their medical residency or internship, or have received their certification after June 1, 1987, and have graduated from a school in Florida.

In return, loan recipients are required to work full-time in a clinical capacity on a year for year repayment basis. Service obligations not completed require the repayment of the total loan amount plus interest on all payments received, calculated at 1 percent per month from the date of payment, plus a practitioner replacement penalty of $5,000.

Contact

Greg Glass or Phil Pettijohn
HRS-Health Manpower Programs
1317 Winewood Boulevard
Tallahassee, Florida 32299-0700
(904) 487-2044

Cross Reference

Maintaining Obstetrical Services

Illinois

Program

Illinois' Education Loan Repayment Program for Physicians provides funds for repayment of education loans of primary care physicians who agree to serve in designated shortage areas for a specified period of time, no less than two years. The maximum annual payment that may be made to an individual under this program is $20,000 or 25 percent of the total covered educational indebtedness, whichever is less.

Contact

Alvin B. Grant
Illinois Department of Public Health
Center for Rural Health
535 West Jefferson Street
Springfield, Illinois 62671
(217) 782-1624

Illinois

Program

The Illinois Medical Student Scholarship program is designed to increase the number of primary care physicians practicing in areas of Illinois needing additional primary care physicians. Scholarship awards will pay for tuition, fees, and liing expenses. (Living expenses are paid at $600/month for twelve months a year.) Immediately after licensure as a physician, the recipient repays the award by establishing a primary care practice in an area in Illinois designated as a Medically Underserved Area.

Contact

Alvin B. Grant
Center for Rural Health
Illinois Department of Public Health
535 West Jefferson
Springfield, Illinois 62761
(217) 782-1624

Kansas

Program

In an effort to encourage students in the University of Kansas School of Medicine to practice medicine and surgery' in the state, the legislature established the Kansas Medical Scholarship Program. The scholarship is available to financially needy Kansas residents pursuing a degree of doctor of medicine. The program offers two types of scholarships. The Type I scholarship covers tuition and provides living expenses of $500 per month for each month a student is enrolled in the university. The Type II scholarship covers tuition only. In return for the scholarship support, upon completion of their program, recipients must engage in full-time medical practice for a period of twelve months in a Kansas city with a population of 12,000 or less (excluding cities in Johnson, Wyandotte, Shawnee, and Sedgwick counties). Persons failing to satisfy the service obligations must repay the full scholarship amount to the university within five years.

Contact

Donna Kempin
Office of Student Affairs
Student Center, Room 300
University of Kansas Medical Center
Kansas City, Kansas 66103
(913) 588-4698

Kansas

Program

The Kansas Nursing Scholarship Program was established in 1989 by the state legislature in an effort to address the nursing shortage in the state. Scholarships, up to 250 per year, are awarded to nursing students in a number of nursing programs. One of these is the Registered Professional Nursing (RPN) Program. About 100 scholarships of $3,500 are available to nursing students in RPN programs. Half of each nursing scholarship is funded by the state of Kansas and half is provided by a medical care provider (sponsor). Scholarship recipients are required to practice one year with the sponsoring medical provider for each year of scholarship assistance received.

Contact

Kansas Nursing Scholarship Program
Kansas Board of Regents
Suite 609, Capitol Tower
400 S.W. 8th
Topeka, Kansas 66603-3517

Kentucky

Program

The Rural Kentucky Scholarship Fund, Inc. provides loans to Kentucky medical students in return for subsequent practice in a physician shortage county for a defined period of time. Loan repayment is forgiven if the practice is in a county defined as "critical." This nonprofit enterprise, a subsidiary of the Kentucky Medical Association, was, for many years, subsidized by the state.

Contact

Eileen Dougherty
Administrator
Rural Kentucky Medical Scholarship Fund, Inc.
3532 Ephraim McDowell Drive
Louisville, Kentucky 40205
(502) 459-9790

Minnesota

Program

Legislation passed in 1990 provides state funds for a physician loan forgiveness program and for nursing scholarships for personnel practicing in rural areas.

Contact

Marianne Miller
Director
Health Economics Program
Minnesota Department of Health
717 S.E. Delaware Street
Minneapolis, Minnesota 55440
(612) 623-5520

Nebraska

Program

The Nebraska Medical Student Loan Program was established in 1978 to help alleviate the problems of shortage and maldistribution of physicians within the state. The program is administered by the Department of Health and the Governor's Commission on Rural Health Manpower. This program is open to Nebraska residents accepted for admission into an accredited medical school in the state. The recipient must agree to practice primary care medicine in an area of the state designated by the commission as a medical shortage area. Repayment is based on substitution of a year of work for a year of loan forgiveness. Financial assistance is limited to $9,000 per year per student, and the total amount of assistance per student is limited to $36,000. Repayment of the loan, including interest, is deferred until the shortage area obligation is completed. In cases of default, interest is set at the highest rate permissible by state law and begins accruing as of the date each loan was executed.

Contact

Kay Pinkley
Nebraska Medical Student Loan Program
P.O. Box 95007
301 Centennial Mall South
Lincoln, Nebraska 68509
(402) 4712337

Cross Reference

Attracting Health Care Professionals: Medically Underserved Areas

Nevada

Program

Program

The Nevada Health Services Corps, established in July 1989, provides loan repayment to health care professionals willing to serve in Medically Underserved Areas. Unlike many loan programs, thii program is targeted toward health care professionals already practicing. The program will repay up to $15,000 per year toward loan responsibilities. Recipients work in a Medically Underserved Area with loan repayment based on a year of work for a year of loan forgiveness, with a minimum eighteen-month commitment.

Contact

Caroline Ford
Director
Office of Rural Health
University of Nevada School of Medicine
MacKay Science Building
Room 201
Reno, Nevada 89557-0046
(702) 784-484 1

Cross Reference

Attracting Health Care Professionals: Medically Underserved Areas, Attracting Health Care Professionals: Recruitment and Retention

New Mexico

Program

Student loan programs are available for medical student, osteopath medical students, and nursing students. These programs were established to provide loans to students who agree to practice in underserved areas upon completion of their education. Loan forgiveness is provided for actual practice in underserved areas. The medical student loan program provides $10,000 per year with a maximum of $40,000 for four years of medical school. This loan is paid back through a three-year commitment to provide service to a rural area.

Contact

Harvey Licht
Primary Care Section
Health and Environment Department
1190 St. Francis Drive
Santa Fe, New Mexico 87503
(505) 827-2527

Cross Reference

Attracting Health Care Professionals: Medically Underserved Areas

Oklahoma.

Program

The Physician Community Match Program is a program matched by the state of Oklahoma through the Physician Manpower Training Commission and a rural Oklahoma community. The program, established to assist Oklahoma's rural communities with a population of 10,000 or less, provides financial assistance to physicians upon starting practice in a sponsoring community. The loan amounts vary, ranging from a minimum of $20,000 to a maximum of $40,000 for a minimum service obligation of two years of practice in the sponsoring community. The amounts are received in a lump sum. If the physician decides not to fulfill his/her obligation to a sponsoring community, he/she would owe in lump sum the total amount plus 12 percent interest and up to a 100 percent penalty.

Contact

John Hanley
Placement Coordinator
Physician Manpower Training Commission
1000 Northeast 10th
P.O. Box 53551
Oklahoma City, Oklahoma 73152
(405) 271-5848

Cross Reference

Attracting Health Care Professionals: Recruitment and Retention

Oklahoma

Program

A Matching Scholarship Loan Program is available for nursing students. The program is supported by a 50 percent match from both the state of Oklahoma and a health institution interested in securing the services of the nurse upon graduation. Sponsors may be hospitals, nursing homes, other health care delivery facilities, communities and health-related corporations, organizations, or foundations. These scholarships range from $1,000 to $2,000. Recipients are obligated to practice nursing at the sponsoring institution one year for each academic year of financial assistance received or repay the scholarship loan plus interest and/or penalty.

Contact

Physician Manpower Training Commission
N.E. 10th and Stonewall
Room 211
P.O. Box 53551
Oklahoma City, Oklahoma 73152
(405) 271-5848

Oregon

Program

The Rural Health Services Program was authorized to provide loan forgiveness to physicians and nurse practitioners who agree to practice in a medically underserved rural community as determined by the Office of Rural Health. The program, administered by the State Scholarship Commission, allows applicants to receive amounts not to exceed $7500 for each year of medical or graduate school. Within five years of completion of residency, a physician agrees to practice at least three full years in a medically underserved community in Oregon. A nurse practitioner must practice at least two years and not more than four years in a medically underserved rural area. If the participant does not complete the full service obligation, 125 percent of all payments by the commission will be owed and must be paid back to the Rural Health Service Fund.

Contact

Karen Whitaker
Office of Rural Health
Health Sciences University
3181 SW Sam Jackson Park Road, MP250
Portland, Oregon 97201-3098
(503) 4944450

Cross Reference

Attracting Health Care Professionals: Medically Underserved Areas

South Dakota

Program

South Dakota's Physician Tuition Reimbursement Program is available to family physicians serving communities with 2,500 residents or less. The program eventually pays any qualified family physician who practices in an eligible community a sum equal to the tuition paid while attending medical school. Half is paid while attending medical school. The full amount is split equally between the state and the community.

Contact

Bernie Osberg
Manager
Office of Rural Health
523 East Capitol Avenue
Pierre, South Dakota 51501
(605) 773-3361

South Dakota

Program

Recent legislation created a Medical Scholarship Program that waives the tuition at the state school of medicine for students who plan to stay in the state and practice in underserved/rural areas.

Contact

Bernie Osberg
Manager
Office of Rural Health
523 East Capitol Avenue
Pierre, South Dakota 51501
(605) 773-3361

Texas

Program

The state of Texas established a Physician Student Loan Repayment Program to assist physicians with loan obligations who are willing to practice in one of four major state agency settings or in a rural or economically depressed community that is medically

underserved. The state will repay up to $9,000 of undergraduate, graduate, or professional student loans for a maximum of five years or $45,000. Participants also may be eligible for a matching federal grant program, also managed by the Texas Higher Education Coordinating Board.

Contact

Physician Student Loan Repayment Program
Division of Student Services
Texas Higher Education Coordinating Board
P.O. Box 12788
Austin, Texas 7871 l-2788
(5 12) 462-6325

Washineton

Program

Enacted in 1988, the Nurse Conditional Scholarship Program provides scholarships to future licensed practical nurses, associate degree registered nurses, baccalaureate degree nurses, and masters degree nurses who may or may not become advanced registered nurse practitioners. As a condition of the scholarship, the recipient is to provide nursing services for five years in a nurse shortage area determined by the Department of Health.

Contact

Marilyn Sjolund
Nurse Scholarship Program
Higher Education Coordinating Board
917 Lakeridge Way
Mailstop - G.V. 11
Olympia, Washington 98504
(206) 753-1147

Washington

Program

The Health Professions Loan Repayment Program pays up to $15,000 per year for three years in educational loans to osteopathic and allopathic physicians, physician assistants, registered nurses, licensed practical nurses, nurse-midwives, and dentists who agree to serve at least three years in a designated health professionalshortage area.

Contact

Marilyn Sjolund
Nurse Scholarship Program
Higher Education Coordinating Board
917 Lakeridge Way
Mailstop - G.V. 11
Olympia, Washington 98584
(206) 753-1147

West Virginia

Program

The West Virginia State Loan Repayment Program is entering its third year, having placed or retained nine physicians through loan repayment incentives. Using federal (USPHS-NHSC) funds with 25 percent state matching funds, the program repays medical education loans in return for placement or retention of physician in Health Manpower Shortage Areas of the state for an obligation period determined by the amount of the loan.

Contact

Ms. Linda Pinetta
Director
Health Profession Recruitment
Division of Primary Care and Recruitment
Bureau of Public Health
1411 Virginia Street East
Charleston, West Virginia 25301
(304) 3484007

Cross Reference

Maintaining Access to Obstetrical Services

West Virginia

Program — ***The*** Health Professions Recruitment Program recruits primary care physicians for placement in rural primary care centers and hospitals. A questionnaire is distributed annually to all administrators to determine the specialities needed. Geographic profiles that describe the practice facility and community are maintained for each recruiting site. Residency visits are made to all in-state primary care residencies and marketing materials are mailed to residency programs in surrounding states. There is no charge for this service.

Contact

Ms. Linda Pinetta
Director
Health Profession Recruitment
Division of Primary Care and Recruitment
Bureau of Public Health
1411 Virginia Street East
Charleston, West Virginia 25301
(304) 348-4007

Wisconsin

Program — ***The*** Nursing Student Stipend Program provides up to $2,500 per academic year in financial assistance to nursing students enrolled full time in a Wisconsin nursing program. The borrower may receive up to $2,500 based on financial need determined by a national needs analysis. The borrower's outstanding principle may not exceed $5,000. Loans not forgiven must be repaid based on 5 percent per annumon the unpaid balance. Loans will be forgiven if the borrower is employed as a registered nurse in a Wisconsin hospital, nursing home, or home health agency, on a twelve-months work equal to $1,000 basis.

Contact

Richard Heinz
Department of Health and Social Services
P.O. Box 1808
Madison, Wisconsin 15370-1808
(608) 267-7122

Medically Underserved Areas

Arkansas

Program — The Office of Primary Care conducts physician and other health personnel surveys periodically to assess the health care needs of Arkansas. The office also serves as a state manpower clearinghouse, matching physicians with communities in need of physician services. This process also involves recruitment of physicians and placement of National Health Service Corps rotators.

Contact

Yvette Lamb
Office of Primary Care
Arkansas Department of Health
4815 West Markham Street
Little Rock, Arkansas 72205
(501) 661-2194

Cross ***Reference*** — Attracting Health Care Professionals: Recruitment and Retention

California

Program — ***The*** California Health Services Corps makes available health personnel, physicians, dentists, and vision care providers to rural areas that have inadequate health services.

Contact

Doreen Wysocki
Chief
Local Health Services Section
Department of Human Services
714/744 P Street
P.O. Box 942732
Sacramento, California 94234-7320
(916) 224-4701

California

Program

The Local Health Service Program Section, using either contract funds or state staff, provides publichealth nursing and environmental health services to those counties with less than 40,000 residents. In addition, technical assistance and consultation is provided to those counties transitioning to an independent health department.

Contact

Doreen Wysocki
Chief
Local Health Services Section
Department of Human Services
714/744 P. Street
P.O. Box 942732
Sacramento, California 94234-7320
(916) 224-4701

Cross Reference

Improving Agricultural and Occupational and Environmental Safety: Occupational and Environmental Health and Safety

Indiana

Program

The Indiana Medical and Nursing Grant Fund awards grants to licensed physicians and nurses who agree to work in Health Manpower Shortage Areas and Medically Underserved Areas. Health care professionals can receive funding annually for up to three years. A 50 percent match is required of the community, but the match does not have to he in actual dollars. For example, a community could provide office space for a year in place of the financial assistance.

Contact

Karen Darwish
Indiana State Board of Health
Indiana Medical and Nursing Grant Fund
1330 West Michigan Street
P.O.Box 1964
Indianapolis, Indiana 46206-1964
(317) 633-8534

Kansas

Program

In Kansas, the Board of Emergency Medical Services oversees the state's emergency medical services, including training, examination, and certification of ambulance attendants. Emergency (911) services exist throughout the state with more than 180 volunteer services in rural areas. A number of new initiatives have been undertaken recently by the board to help ensure rural emergency medical services. These initiatives include: creating a program for training and certifying first responders so that good emergency care can he provided at the scene while the ambulance is still enroute; and implementing a series of weekend workshops for ambulance service directors with information on recruiting volunteers, funding sources, technical assistance, and community relations.

Contact

Bob McDaneld
Board of Emergency Medical Services
109 SW 6th Street
Topeka, Kansas 66603-3805
(913) 2%72%

Cross ***Reference***

Improving Emergency Medical Care

Kentucky

Program The Kentucky Physician Placement Service, an agency of the Department of Health Services, recruits primary care physicians for placement in predominantly rural, medically underserved counties. Recruitment is on behalf of community requests made primarily by local hospital administrators and physicians. There is no charge to either party for this service.

Contact
Don Coffey
Manager
Community Health Development Branch
Department for Health Services
275 East Main Street
Frankfort, Kentucky 40621
(502) 564-3386

Cross ***Reference*** Coordinating Activities, Attracting Health Care Professionals: Recruitment and Retention

Maine

Program *The* Maine Cooperative Agreement for Primary Care Services was implemented on October 1, 1985. The cooperative agreement is a three-way agreement among the federal government, the state's primary care association, and the state of Maine. Its focus is to coordinate federal and state primary care resources; help medically underserved populations and health care providers recruit and retain physicians and other health professionals; promote the use of state primary care resources; promote affiliations and coordination with area health providers and the state's health department, area health education centers, hospitals, and residency programs. In addition, the cooperative agreement maintains an active clearinghouse of site vacancies and health care provider files.

Contact
Sophie Glidden
Rural Health Program Manager
Department of Human Services
Augusta, Maine 04333
(207) 289-2716

Cross Reference Attracting Health Care Professionals: Recruitment and Retention, Coordinating Activities

Minnesota

Program Legislation passed in 1990 increased funding to the University of Minnesota Rural Physicians Associates Program (RPAP), which arranges rural rotations for medical students. It also funded a summer intern program for high school students, in which up to fifty students per year are placed in rural health care settings to work each summer, heightening their awareness of opportunities in these settings.

Contact
Marianne Miller
Director
Health Economics Program
Minnesota Department of Health
717 S.E. Delaware Street
Minneapolis, Minnesota 55440
(612) 623-5520

Nebraska

Program *The* Nebraska Medical Student Loan Program was established in 1978 to help alleviate the problems of shortage and maldistribution of physicians within the state. The program is administered by the Department of Health and the Governor's Commission on Rural Health Manpower. The program is open to Nebraska residents accepted for

admission into an accredited medical school in the state. The recipient must agree to practice primary care medicine in an area of the state designated by the commission as a medical shortage area for one year per year of the received loan. Financial assistance islimited to $9,000 per year per student, and the total amount of assistance per student is limited to $36,000. Repayment of the loan, including interest, is deferred until the shortage area obligation is completed. In cases of default, interest is set at the highest rate permissible by state law and begins accruing as of the date each loan was executed.

Contact

Kay Pinkley
Nebraska Medical Student Loan Program
P.O. Box 95007
301 Centennial Mall South
Lincoln, Nebraska 68509
(402) 471-2337

Cross Reference

Attracting Health Care Professionals: Education Assistance

Nebraska

Program

Nebraska's Office of Rural Health established a Physician Referral Program for rural Nebraska practice. Physicians in residency training are contacted by the office to identify those whose backgrounds and interests make them candidates for rural Nebraska practice. A roster profiling their practice site preferences is made available to communities seeking physicians.

Contact

David Palm
Director
Office of Rural Health
Nebraska Department of Health
P.O. Box 95007
Lincoln, Nebraska 68509
(402) 471-2337

Nevada

Program

The Nevada Health Services Corps, established in July 1989, provides loan repayment to health care professionals willing to serve in Medically Underserved Areas. Unlike many loan programs, this program is targeted toward health care professionals already practicing. The program will repay up to $15,000 per year toward loan responsibilities. Recipients will work in a Medically Underserved Area with loan repayment based on a year of work for a year of loan forgiveness, with a minimum eighteen-month commitment.

Contact

Caroline Ford
Director
Office of Rural Health
University of Nevada School of Medicine
MacKay Science Building
Room 201
Reno, Nevada 89557-0046
(702) 784-4841

Cross Reference

Attracting Health Care Professionals: Recruitment and Retention, Attracting Health Care Professionals: Education Assistance

New Mexico

Program

Through the Rural Primary Care Act, a clearinghouse was established to assist in the recruitment and retention of health professionals. This clearinghouse recruits physicians, nurses, nurse practitioners, physician assistants, and occupational and physical therapists to serve in rural and underserved areas. The clearinghouse is run by a private, nonprofit organization called New Mexico Health Resources Inc., and is funded through a budget line item under the Rural Primary Care Act.

The state paid between $65,000 to $70,000 for services that recruited approximately fifteen providers to rural and underscrved areas.

Contact

Harvey Licht
Primary Care Section
Health Environment Department
1190 St. Francis Drive
Santa Fe, New Mexico 87503
(505) 827-2527

Cross Reference

Attracting Health Care Professionals: Recruitment and Retention

New Mexico

Program

Student loan programs are available for medical students, osteopath medical students, and nursing students. These programs were established to provide loans to students who agree to practice in underserved areas upon completion of their education. Loan forgiveness is provided for actual practice in underserved areas. The medical student loan program provides $10,000 per year with a maximum of $40,000 for four years of medical school. This loan is paid back through a three-year commitment to provide service to a rural area.

Contact

Harvey Licht
Primary Care Section
Health Environment Department
1190 St. Francis Drive
Santa Fe, New Mexico 87503
(505) 827-2527

Cross Reference

Attracting Health Care Professionals: Education Assistance

North Carolina

Program

The North Carolina Rural Obstetrical Care Incentive Program was established early in 1989 to assist physicians in rural areas with obstetrics malpractice insurance premiums. The first of its kind in the nation, the program provides subsidies for the liability insurance costs for physicians willing to deliver babies in rural underserved areas.

Contact

Richard Lanholz
NCRHRP
Health Services Research Center
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina 27514

Cross Reference

Maintaining Access to Obstetrical Services

Oklahoma

Program

The Physician Community Match Program is a program matched by the state of Oklahoma through the Physician Manpower Training Commission and a rural Oklahoma community. The program, established to assist Oklahoma's rural communities with a population of 10,000 or less, provides financial assistance to physicians upon starting practice in a sponsoring community. The loan amounts vary, ranging from $20,000 to $40,000 for a minimum service obligation of two years of practice in the sponsoring community. The amounts are received in a lump sum. If the physician decides not to fulfill his/her obligation to a sponsoring community, he/she would owe in lump sum the total amount plus 12 percent interest and up to a 100 percent penalty.

Contact

John Hanley
Placement Coordinator
Physician Manpower Training Commission
1000 Northeast Training Commission
P.O. Box 53551
Oklahoma City, Oklahoma 73152
(405) 271-5848

Cross Reference

Attracting Health Care Professionals: Recruitment and Retention

Oregon

Program

The Rural Health Services Program was authorized to provide loan forgiveness to physicians and nurse practitioners who agree to practice in a medically underserved rural community as determined by the Office of Rural Health. The program, administered by the State Scholarship Commission, allows applicants to receive amounts not to exceed $7,500 for each year of medical or graduate school. Within five years of completing a residency, a physician can agree to practice at least three full years in a medically underserved community in Oregon. A nurse practitioner must practice at least two years and not more than four years in a medically underserved rural area. If the participant does not complete the full service obligation, 125 percent of all payments by the commission will be owed and must be paid back to the Rural Health Service Fund.

Contact

Karen Whitaker
Office of Rural Health
Health Sciences University
3181 SW Sam Jackson Park Road, MP250
Portland, Oregon 97201-3098
(503) 494-4450

Cross Reference

Attracting Health Care Professionals: Education Assistance

Oregon

Program

Senate Bill 438, passed by the 1989 Legislative Assembly, provides a number of new approaches designed to support health care professionals in rural areas of Oregon. Beginning January 1, 1990 and ending December 31, 1993, certain physicians, physician assistants, and nurse practitioners practicing in certain rural areas are allowed an annual income tax credit of $5,000. Income tax credits are allowed for those practicing rural health care professionals meeting specific requirements including: any physician (not limited to primary care) on the medical staff of a Type A, B, or C hospital if 60 percent of their practice is in a rural area; and any physician, physician assistant, or nurse practitioner not on a medical staff if they can admit a patient to a hospital and 60 percent of their practice is in a rural area.

Contact

Karen Whitaker
Office of Rural Health
Health Sciences University
3181 SW Sam Jackson Park Road, MP250
Portland, Oregon 97201-4950
(503) 4944450

Cross *Reference*

Attracting Health Care Professionals: Recruitment and Retention, Attracting Health Care Professionals: Medically Underserved Areas

Texas

Program

The Primary Care Services and Manpower Placement Program was established to develop strategies for coordination of state and federal resources to implement community-based primary care delivery systems for the purpose of assuring services to the medically needy in prioritized underserved areas. The goals of the program are to continue to identify and validate high need areas using the HMSA and MUA designation system; continue to develop strategies for the recruitment and retention of needed

health manpower for high-need areas; and to continue to update a basic state primary care needs/demand assessment.

Contact

Barry Good
Primary Care Services and Manpower Placement Program
Texas Department of Health
1100 - West 49th Street
Austin, Texas 78756
(512) 458-7771

Cross Reference

Improving Access to Health Care for the Medically Indigent

Vermont

Program

The Barre Maternity Care Program is a midwife-family planning clinic model with external linkages to other health department services. A midwife, backed up by a local obstetrician, provides all prenatal and delivery services. The program serves approximately seventy-three pregnant women a year with a budget of $60,000.

Contact

Diane St. Claire
Health Planner
Department of Health
1193 North Avenue
P.O. Box 70
Burlington, Vermont 05402

Cross *Reference*

Maintaining Access to Obstetrical Services

MAINTAINING ACCESS TO OBSTETRICAL, SERVICES

Florida

Program

The 1985 Florida Legislature created the Medical Education Tuition Reimbursement Program to encourage qualified medical professionals to practice in underserved locations. Applicants must be physicians, nurse practitioners, and physician assistants with specialties in obstetrics/gynecology, general/family practice, internal medicine, and pediatrics, and can receive up to $10,000 per year or an amount equivalent to one-third of the total tuition and registration fees for three years. In addition, graduates must have completed their medical residency or internship, or have received their certification after June 1, 1987, and have graduated from a school in Florida.

In return, loan recipients are required to work full time in a clinical capacity on a year for year repayment. Service obligations not completed require repayment of total loan amount plus interest on all payments received, calculated at 1 percent per month from the date of payment, plus a practitioner replacement penalty of $5,000.

Contact

Greg Glass or Phil Pettijohn
HRS - Health Manpower Program
1317 Winewood Boulevard
Tallahassee, Florida 32299-0700
(904) 487-2044

Cross Reference

Attracting Health Care Professionals: Education Assistance

Florida

Program

The Healthy Beginnings Project currently is working toward a system for continuity of care for pregnant women. The plan, which would initially cost the state $1.3 million, includes using sites located in Okaloosa, Walton, and Holmes counties for prenatal care. Deliveries will be done at Crestview hospital for low-risk indigent women and at Sacred Heart for high-risk deliveries. Care will be given by the Northwest Florida OB/GYN Foundation Residents at the four sites. Medicaid would be billed by the

foundation with the revenue going to the Health and Rehabilitation Service, County Public Health Unit (HRS CPHU). The foundationwill be paid out of these funds. The proposal includes the use of automated prenatal health records for all patients so that they are immediately retrievable at any of the clinics and delivery sites. Each of the sites are equipped with monitoring equipment with electronic transmission capability, for immediate consultation with a Sacred Health perinatologist.

Contact

Greg Glass or Phil Pettijohn
HRS - Health Manpower Program
1317 Winewood Boulevard
Tallahassee, Florida 32299-0700
(904) 487-2044

Cross Reference

Improving Access to Health Care for the Medically Indigent

Florida

Program

The Child Health Passport/Pediatric Case Manager Program in Gadsen County is a cooperative effort between private pediatricians, the health department, the county hospital, and two new physicians in the county. The passport, in a plastic case, is issued to all children born in the county hospital and to all children under age one as they come to their provider for care. It is updated by all who treat these children. It provides space for notation of regular child health visits and immunizations, illnesses, emergency room visits, and frequently needed data such as height, weight, and hemocyte. Cost of the development was borne by the providers themselves. Nurse case managers monitor the health care of all children born in the county and referred as high-risk children from neighboring county hospitals.

Contact

Betty Serow
HSFHG
1317 Winewood Boulevard
Tallahassee, Florida 32399-0700
(904) 4884226

Iowa

Program

Through a Centers for Disease Control grant, Iowa has established a community-based disability prevention project targeted at high-risk pregnant women. The goal of the program is to reduce the rate of birth defects and low-birthweight babies through reduction of known prenatal risk factors such as teen pregnancy, smoking, and alcohol and drug abuse.

Contact

Roger Chapman
Program Manager
Iowa Department of Public Health
Des Moines, Iowa 50311
(515) 281-6646

Cross ***Reference***

Improving Access to Mental Health, Alcohol, and Substance Abuse Treatment

North Carolina

Program

The Maternal and Child Health Project assists twenty-two primary care centers in providing intensive perinatal services. The maternity consultants have developed and implemented manual and computerized management information systems in each center. In addition, assistance includes community organizing, program development and consulting, information systems development, grant writing, and publications.

Contact

Ann Wolfe
Division of Maternal and Child Health
701 Barbour Drive
Raleigh, North Carolina 27603
(919) 733-3816

Cross ***Reference***

Providing Financial and Technical Assistance: Technical Assistance

North Carolina

Program The North Carolina Rural Obstetrical Care Incentive Program was established early in 1989 to assist physicians in rural areas with obstetrical malpractice insurance premiums. The first of its kind in the nation, the program provides subsidies for the liability insurance costs for physicians willing to deliver babies in rural, underserved areas.

Contact
Richard Lanholz
NCRHRP
Health Services Research Center
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina 27514

Cross Reference Attracting Health Care Professionals: Medically Underserved Areas

Vermont

Program The Barre Maternity Care Program is a midwife-family planning clinic model with external linkages to other health department services. A midwife, backed up by a local obstetrician, provides all prenatal and delivery services. The program serves approximately seventy-three pregnant women a year with a budget of $60,000.

Contact
Diane St. Claire
Health Planner
Department of Health
1193 North Avenue
P.O. Box 70
Burlington, Vermont 05402
(802) 863-7347

Cross Reference Attracting Health Care Professionals: Medically Underserved Areas

Vermont

Program The Vermont Legislature appropriated $200,000 to the Department of Health to award grants to local communities for creating innovative solutions to obstetrical shortages in rural areas of the state. Six grants were awarded to a variety of communities and services statewide. The projects include establishing a single-point access maternity care system in the Gifford Hospital area, a salary for a nurse midwife, and an award to an individual to pay for nurse midwife training in exchange for one year of service. Other projects include developing a program of Lamaze education, especially for low-income women or those on Medicaid, and support for nurse midwifery, nutrition, social services, nursing, and support personnel in hospitals' prenatal care clinics, and developing a training program for mid-level practitioners in prenatal care.

Contact
Diane St. Claire
Health Planner
Department of Health
1193 North Avenue
P.O. Box 70
Burlington, Vermont OS402
(802) 863-7347

Cross Reference Providing Financial and Technical Assistance: Financial Assistance

West Virginia

Program The Local Availability Project provides salary and educational expenses to West Virginia registered nurses accepted into certified programs for nurse midwives or ob/gyn nurse practitioners. The program, which began in 1989, presently has a number of nurses in training and is expecting more to enter. The goal of the program is to have fifteen fully trained by 1992.

Contact

Charles Dawkins
1411 Virginia Street East
Charleston, West Virginia 25301
(304) 348-4007

IMPROVING EMERGENCY MEDICAL CARE

Alaska

Program

Alaska uses a rural telecommunications grid as a way of providing continuing education services. Using a telecommunications grid, more than 100 people can participate in meetings via the telephone.

Contact

Mark Johnson
Department of Health and Social Service
Pouch HO2
Juneau, Alaska 99811
(907) 465-3027

Alaska

Program

Alaska uses mobile trauma vans to provide emergency services education and training to EMS providers in rural areas. The van travels throughout different parts of the state, staying in an area for a few days to provide training on a specific care issue (e.g., trauma care of cardiac patients) and then moving on to the next location.

Contact

Mark Johnson
Department of Health and Social Service
Pouch HO2
Juneau, Alaska 99811
(907) 4653027

Alaska

Program

Alaska brings emergency medical technicians (EMTs) into rural areas to train community residents as instructors. This process decentralizes the training process, making training available to residents of remote areas. Certified instructors return to rural areas and are qualified to train local residents as EMS providers. As a result of this program Alaska has 150 certified instructors. The state has set strict standards and requires recertification every two years.

Contact

Mark Johnson
Department of Health and Social Service
Pouch HO2
Juneau, Alaska 99811
(907) 4653027

California

Program

The County Medical Services Program, which has been in existence in rural counties since 1983, provides medical coverage for indigent adults who meet Medi-Cal (Medicaid) eligibility standards, but who are not categorically linked to the Medi-Cal program. This program recently was expanded to cover emergency treatment for indigent non-county residents.

Contact

James Martinez
Chief
714 P Street, Room 523
Sacramento, California 95814
(916) 739-3149

Cross Reference

Improving Access to Health Care for the Medically Indigent

Colorado

Program

The state of Colorado developed a new licensure category for rural providers called Community Clinic/Emergency Centers (CCECs). CCECs provide only emergency and outpatient services, but they must have a written affiliation with a nearby general hospital to coordinate patient referral services needs. The CCECs have a maximum of six beds to stabilize patients for up to seventy-two hours. The facilities must have twenty-four hour skilled nursing coverage available on site, with a physician availabie by phone and within fifteen minutes travel time.

Contact

Paul Daraghy
Director of Health Facilities
Colorado Department of Health
4210 E 11th Avenue
Denver, Colorado 80220
(303) 331-4990

Cross Reference

Maintaining Existing Health Care Facilities

Florida

Program

Florida established a new category with requirements similar to the facility requirements of MAFs. Emergency Care Hospitals (ECHs) must be located within counties with less than 101 persons per square mile and be either the sole provider in that county or at least thirty minutes travel time from any other similar hospital. Florida's ECH laws also vary from the MAF laws in that ECHs retain their license as a hospital, giving them additional flexibility in terms of the services they can provide.

Contact

Richard Polangin
Health Services and Facilities Consultant
HRS, PDRHP
2727 Mahan Drive
Tallahassee, Florida 32308
(904) 48883%

Cross Reference

Maintaining Existing Health Care Facilities

Idaho

Program

Idaho uses a mobile training van to deliver training programs in a special care area. For example, a training van may provide training on the treatment of cardiac arrest or trauma. The van may travel to several areas throughout the state providing training on this particular topic.

Contact

Paul Anderson
450 West State, 3rd Floor
Bureau of Emergency Training Medical Services
Boise, Idaho 83720
(288) 334-5994

Illinois

Program

The Center of Rural Health provides technical assistance to communities/counties to help them initiate or expand emergency medical services. The results of the confidential interview survey in one county revealed the residents' need for emergency services. The County Board Chairman appointed a committee to develop a plan of action. As a

result, two additions were made to the November ballot: a 911 system; and a tax levy to support ambulance services. The committee and center staff have been meeting with local residents and groups to increase awareness of the issues and provide answers to their questions.

Contact

Thomas Yocom
Center For Rural Health
Illinois Department of Public Health
535 West Jefferson
Springfield, Illinois 62761
(217) 782-1624

Iowa

Program

In 1989 the Iowa General Assembly approved a plan to permit first responders to utilize automatic defibrillators prior to the arrival of an ambulance. This program is expected to reduce the time between cardiac arrest and defibrillation in rural areas.

Contact

Don Kerns
Emergency Medical Services Program Manager
Iowa Department of Public Health
Lucas State Office Building
Des Moines, Iowa 50319
(515) 2813239

Kansas

Program

The Kansas Board of Emergency Medical Services oversees the emergency medical services in the state, including training, examination, and certification of ambulance attendants. Emergency (911) services exist throughout the state with more than 180 volunteer services in rural areas. A number of new initiatives have been undertaken recently by the board to help ensure rural emergency medical services. These initiatives include creating a program for training and certifying first responders, so that good emergency care can be provided at the scene while the ambulance is still enroute; and implementing a series of weekend workshops for ambulance service directors with information on recruiting volunteers, funding sources, technical assistance, and community relations.

Contact

Bob McDaneld
Board of Emergency Medical Services
109 SW 6th Street
Topeka, Kansas 66603-3805
(913) 296-7296

Minnesota

Program

The Minnesota Department of Health's Emergency Medical Services program credentials EMTs and paramedics and oversees the operation of EMS systems throughout the state. The program currently is working on legislative proposals to increase the supply of EMTs and to provide other incentives to foster recruitment and retention of EMS personnel.

Contact

Norm Hanson
Chief
Minnesota Department of Health
Central Medical Building
393 North Dunlap Street
St. Paul, Minnesota 55164
(612) 643-2164

Cross Reference

Coordinating Activities

North Dakota

Program

In 1989 the North Dakota Legislature mandated the development of regional community-based chemical dependency services. Funding was made available to each of eight regional human service centers to further expand the continuum of care so persons can be more efficiently served closer to home. The new services will include social detoxification, a safe supportive environment in which an individual may withdraw from chemicals of abuse; emergency medical services, providing medical detoxification for those whose condition warrants the service; and long-term residential care, designed to provide long-term support and a sober environment, particularly to the client who is exceedingly relapse-prone or who has needs that may interfere with recovery.

Contact

John Allen
Director
Division of Alcoholism and Drug Abuse
Department of Human Services
Bismark, North Dakota 58505
(701) 224-2769

Cross Reference

Improving Access to Mental Health, Alcohol, and Substance Abuse Treatment

Vermont

Program

Vermont now uses an automatic defibrillation system. Automatic defibrillation uses voice prompts to indicate to emergency medical personnel when defibrilliation is appropriate. The rescuer is only required to press a button. This automated system simplifies the training process, thus making training a less timely process. Presently, these systems are being used by most rural emergency squads on a trial basis.

Contact

Dan Manz
EMS Division
Vermont Department of Health
Box 70
Burlington, Vermont 05402
(802) 863-7310

Washington

Program

The EMS Mobile Training Unit was established to assist emergency medical care providers with mandated continuing education requirements. The program has two objectives: to actually take the instruction into rural communities and to enhance existing rural emergency care providers' education by providing local instructors with up-to-date resources and support.

In its first year of operations the training unit provided instruction at or near most rural communities in the North Central and East EMS regions. A total of 121 classes were presented to more than 1,568 participants.

Contact

Jack Cvitanovia
EMS Mobile Training
Department of Health
Olympia, Washington 98504
(206) 753-1095

Wisconsin

Program

The Emergency Medical Technician Training and Examination Aide Program allocates funds for ambulance service vehicles and equipment to EMS entities. The program also allocates funds to entities whose courses or instructional programs are approved by the department to assist in providing training required for licensure and renewal of licensure as an EMT.

Contact

Richard Heinz
Department of Health and Social Services
Division of Health, Primary Care Programs
P.O. Box 1808
Madison, Wisconsin 53701-1808
(608) 267-7122

Improving Access to Health Care for the Medically Indigent

Arizona

Program

The Mobile Clinic Project of Pima County provided primary care services to underserved, low-to moderate-income communities in unincorporated Pima County. In addition, the project promotes each community's involvement in the improvement of its health services. Since May 1987 more than 500 persons have been served in four communities. The clinic visits each community two times each month for three to four hours. The program trains community volunteers to carry out receptionist and office nurse duties.

Contact

Augusto Ortiz
Rural Health Office
Department of Famiiy and Community Medicine
College of Medicine
University of Arizona
3131 East Second Street
Tucson, Arizona 85716
(602) 626-7946

Arkansas

Program

The Arkansas Medical Society, through its Arkansas Health Care Access Foundation, serves as a clearinghouse of volunteer primary care practitioners accessible via a "1-800" hotline number.

Contact

Ken LaMastus
Executive Director
Arkansas Medical Society
10 Corporate Hill Drive
Little Rock, Arkansas 72215
(501) 224-8967

California

Program

The County Medical Services Program, which has been in existence in rural counties since 1983, provides medical coverage for indigent adults who meet Medicaid (Medi-Cal) eligibility standards, but who are not categorically linked to the Medi-Cal program. Thii program recently was expanded to cover emergency treatment for indigent non-county residents.

Contact

James Martinez
Chief
714 P Street, Room 523
Sacramento, California 95814
(916) 7393149

Cross *Reference*

Improving Emergency **Medical Care**

Florida

Program

The Healthy Beginnings Project currently is working toward a system for continuity of care for pregnant women in the area. The plan, which would initially cost the state $1.3 million, includes using sites located in Okaloosa, Walton, and Holmes counties for prenatal care. Deliverieswill be done at Crestview hospital for low-risk indigent women and at Sacred Heart for high-risk deliveries. Care will be given by the Northwest Florida OB/GYN Foundation residents at the four sites. Medicaid will be billed by the foundation with the revenue going to the HRS CPHU. The foundation will be paid out of these funds. The proposal includes the use of automated prenatal health records for all patients so that they are immediately retrievable at any of the clinics and delivery sites. Each of the sites have monitoring equipment with electronic transmission capability, for immediate consultation with a Sacred Health perinatologist.

Contact

Richard Polangin
Health Services and Facilities Consultant
HRS, PDRHP
2727 Mahan Drive
Tallahassee, Florida 32308
(904) 488-8396

Cross Reference

Improving Access to Health Care for the Medically Indigent

Iowa

Program

Since about 1930, the University of Iowa hospitals and clinics have served indigent populations through a state appropriation. The fiscal 1990 appropriation was $26 million.

Contact

William Hesson
Senior Assistant Director
University of Iowa Hospital and Clinics
Iowa City, Iowa 52242
(319) 356-1616

Kentucky

Program

The two-year Acute Ambulatory Care Demonstration Project, conducted from 1986 to 1988, tested the feasibility of providing acute and preventive primary care for non-Medicaid indigents in local health departments. Four local departments, already providers of comprehensive preventive care, contracted with local private physicians to provide the acute care. All care was provided within health departments to ensure case management and cross-referrals to and from preventive care. Although state funding has been terminated, three of the departments continue to fund the services on their own.

Contact

C. Hemandez
Commissioner
Department for Health Services
275 East Main Street
Frankfort, Kentucky 40621
(502) 564-3970

Cross Reference

Establishing Managed Care Initiatives: Health Care Services For All Ages

Minnesota

Program

The Minnesota Department of Human Services currently is working with medical service providers in Lake County in northeastern Minnesota. The goal is to contract with Lake County providers for provision of cost-effective services to low-income residents eligible for the state's General Assistance Medical Care program in that county. The contract will most likely involve some risk sharing or surplus sharing between local providers and the state.

Contact

Patricia MacTaggart
Health Care Management Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155
(612) 297-4671

Cross Reference

Establishing Managed Care Initiatives: Health Care Services For All Ages

North Carolina

Program

Carolina ACCESS is a demonstration program that uses coordinated care arrangements to improve health care to Medicaid patients. Selected counties identify or organize a network of primary care providers who agree to coordinate recipient health care services by providing or arranging primary care services, referrals for specialty services, twenty-four hour access, and assistance in providing service to participants. Managed care can improve access to quality health care for Medicaid recipients by replacing a system that encourages episodic care from a variety of providers with a program that promotes continuity of care through a primary care coordinator.

Contact

Torlen Wade
Assistant Director-Administration
Office of Rural Health and Resource Development
701 Barbour Drive
Raleigh, North Carolina 27603
(919) 733-2040

Cross Reference

Establishing Managed Care Initiatives: Health Care Services For All Ages

Oklahoma

Program

In 1985 the Oklahoma Indigent Health Care Act was amended to provide for a state income tax checkoff for donations to fund indigent health care. A revolving fund called the Indigent Health Care Revolving Fund was created in the Department of Treasury for the Department of Human Services. The fund is not subject to fiscal year limitations. The responsibilities of the Department of Human Services include: to establish and review eligibility standards and criteria for participating clinics; to establish and review the screening process criteria and procedures for persons receiving services through participating clinics; and to determine the type of services offered by participating clinics. State or federally operated medical institutions are not affected with the exception of Oklahoma teaching hospitals.

The services are targeted to medically indigent Oklahomans. Medically needy persons are defined as those persons: with incomes below the poverty level who require medically necessary hospital or primary health care services and are not eligible for or receiving services from a federal or state medical program; and have either a catastrophic injury or illness or a dependent with a catastrophic injury or illness resulting in noncovered incurred medical debt.

Contact

Gerald W. Prillman
Oklahoma Council on Health Care Delivery
Oklahoma State Department of Health
P.O. Box 53551
Oklahoma City, Oklahoma 73152
(405) 27 l-3950

South Carolina

Program

South Carolina is establishing a prepaid health plan (a health maintenance organization) with Orangeburg Family Health Center to serve the needs of rural residents. It is the project's intention to expand to other counties to address rural health needs. In addition, this will complement the Primary Care Association's efforts to attract physicians to Hampton County and similar areas. These programs will improve access, encourage efficient use of health services, and be costeffective.

Contact

Tom Lucas
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 292028206
(803) 252-0953

Texas

Program

In recognition of the growing number of medically indigent in the state and the importance of primary care, the Texas Legislature passed the Primary Health Care Services Act. This legislation requires the Texas Department of Health to develop a health care delivery system to improve access to essential preventive and health services for the medically indigent. With an appropriation of $7,700,000 in fiscal 1986-87, the department's Primary Health Care Services Program funded twenty-six primary health care projects with services being delivered by both private and public health care providers.

Contact

Carol Peters
County Indigent Health Care Program
Texas Department of Human Services
P.O. Box 149030 (Mail Code 518E)
Austin, Texas 787149030
(512) 450-3711

Texas

Program

The Primary Care Services and Manpower Placement Program develops strategies for coordination of state and federal resources to implement community-based primary care delivery systems for the purpose of assuring services to the medically needy in prioritized underserved areas. The goals of the program are to continue to identify and validate high-need areas using the HMSA and MUA designation system; to continue to develop strategies for the recruitment and retention of needed health personnel for high-need areas; and to continue to update a basic state primary care needs/demand assessment.

Contact

John Dombroski
Primary Care Services and Manpower Placement Program
Texas Department of Health
1100 - West 49th Street
Austin, Texas 78756 95120
458-7771

Cross Reference

Attracting Health Care Professionals: Medically Underserved Areas

IMPROVING ACCESS TO MENTAL HEALTH, ALCOHOL, AND SUBSTANCE ABUSE TREATMENT

Arkansas

Program

The Arkansas Office of Alcohol and Drug Abuse Prevention provides grants for community-based substance abuse programs. Programs include prevention, treatment, and educational initiatives.

Contact

Paul Behnke
Arkansas Department of Human Services
Post office 1437
Little Rock, Arkansas 72201
(501) 682-2603

Iowa

Program

Through a Centers for Disease Control grant, Iowa has established a community-based disability prevention project targeted at high-risk pregnant women. The goal of the program is to reduce the rate of birth defects and low birthweight through reduction of known prenatal risk factors such as teen pregnancy, smoking, and alcohol and drug abuse.

Contact

Roger Chapman
Program Manager
Iowa Department of Public Health
Des Moines, Iowa 503 11
(515) 2814646

Cross Reference

Maintaining Access to Obstetrical Services

Kansas

Program

In 1985 the Kansas legislature established the Farmer's Assistance Counseling and Training Service (FACTS). FACTS is a hotline that assists farmers, ranchers, agribusinessmen, and their families in avoiding or alleviating the problems and stress resulting from the agricultural crisis in rural areas. The hotline is a no-cost service offering counseling, assistance, and referrals by professionally qualified specialists. The project is a joint effort between the Kansas State Board of Agriculture and the Kansas Cooperative Extension Service.

Contact

Char Henton
9 Leiiure Hall
Kansas State University
Manhattan, Kansas 66506-3504
(913) 5326958

Cross Reference

Improving Agricultural and Occupational and Environmental Health and Safety: Agricultural Safety

Nevada

Program

The Division of Mental Hygiene and Mental Retardation is the state agency responsible for the planning, development, and coordination of mental health and mental retardation services in Nevada. Service delivery within the division is organized geographically into three regional areas: a northern region, a southern region, and a rural region. The rural region offers mentally retarded persons and mentally ill persons services under the auspices of the Community Mental Health Centers (CMHC).

The CMHC program was developed to provide comprehensive mental health services to the residents of rural Nevada, a population of almost 190,000 people. CMHCs offer twelve basic mental health services: inpatient services, transitional care, partial hospitalization, outpatient services, prescreening, emergency services, children's services, elderly services, alcohol abuse services, and consultation and education. In addition, special programs are provided for rape intervention, Native Americans, Hispanics, domestic violence, and child abuse/neglect.

Contact

Patricia Hardy
Nevada Rural Clinics/Community Mental Health Centers
State Capitol Complex
1001 North Mountain Street
Gilbert Building, Suite 1 - H
Carson City, Nevada 89710
(702) 687-3135

North Dakota

Program

The North Dakota Prevention Resource Center has been in operation for one year. The center offers library services of print, video, and curriculum materials; a

clearinghouse of pamphlets, booklets, posters, brochures, and stickers; and technical assistance for the development of prevention programs in schools and communities. All materials are free to the public. Future plans are to develop a network of prevention programs and people throughout the state.

Contact

John Allen
Director
Division of Alcoholism and Drug Abuse
Department of Human Services
Bismarck, North Dakota 58505
(701) 224-2769

North Dakota

Program

Governor Sinner issued an executive order creating the Policy and Planning Commission for Alcohol and Other Drug Abuse Prevention. The commission consists of representatives of state agencies involved in prevention efforts, two state legislators, a representative of the Governor's office and two citizens-at-large. Its mission is to develop a comprehensive plan to coordinate efforts and to reduce duplication or gaps in programs and services in the state.

Contact

John Allen
Director
Division of Alcoholism and Drug Abuse
Department of Human Services
Bismark, North Dakota 58505
(701) 224-2769

Cross ***Reference***

Coordinating Activities

North Dakota

Program

In 1989 the North Dakota Legislature mandated the development of regional community-based chemical dependency services. Funding was made available to each of eight regional human service centers to further expand the continuum of care so persons can be more efficiently served closer to home. The new services will include: social detoxification, a safe supportive environment in which an individual may withdraw from chemicals of abuse; emergency medical services, providing medical detoxification for those whose condition warrants the service; and long-term residential care, designed to provide long-term support and a sober environment, particularly to the client who is exceedingly relapse-prone or who has needs that may interfere with recovery.

Contact

John Allen
Director
Division of Alcoholism and Drug Abuse
Department of Human Services
Bismark, North Dakota 58505
(701) 224-2769

Cross ***Reference***

Improving Emergency Medical Care

Washington

Program

Mental Health Nursing Scholarships are aimed at nurses who agree to work for one of the two state mental hospitals or for community mental health providers in underserved areas.

Contact

Nancy Wheeler
DSHS-Mental Health Division
12th and Franklin
Mail Stop OB42-F
Olympia, Washington 95804
(206) 5866727

ESTABLISHING MANAGED CARE INITIATIVES

Services To Elderly Populations

Iowa

Program

Several counties in Iowa offer managed care services to residents over age sixty. Local agencies serving the elderly have agreed to coordinate their services, so that individuals can remain in their homes. Through case management, a team of local agency staff work together to meet an individual's needs. One person from the team is the case manager and is responsible for making sure that the individual obtains necessary assistance. The case management services are free to county residents over age sixty, however, agencies charge for their own services.

Contact

Kathy Cairns
Long Term Care Coordinator
Iowa Department of Elderly Affairs
914 Grand Avenue
236 Tewett Building
Des Moines, Iowa 50304
(515) 281-3019

Kansas

Program

The Kansas Senior Care Act is a special project to provide personal care and homemaking services to persons sixty years of age or older who reside in rural northeast Kansas. Residents of Brown, Nemaha, Jackson, and Doniphan counties are eligible. The program is jointly funded by the Kansas Department on Aging and the Community Programs for Accessible Health Care.

Contact

Bill Cutler
Kansas Department on Aging
Docking SOB
122 South
915 S.W. Harrison
Topeka, Kansas 66612
(913) 296-4986

Nebraska

Program

In 1987 the Nebraska Legislature passed the Care Management Services Act, mandating the Department on Aging to develop a statewide network of certified care management. Nebraska's care management utilizes a client-centered approach to service provision. Since passage of the act, at least one care management unit has been established within each Area Agency's planning and service area. During fiscal 1989, care management units provided 6,342 units of direct service to 1,457 disabled elderly clients.

Contact

Betsy Palmer
Department of Health
301 Centennial Mall South
P. 0. Box 95007
Lincoln, Nebraska 68509-5007
(402) 471-2306

Health Care Services For All Ages

Kentucky

Program

The two-year Acute Ambulatory Care Demonstration Project, conducted from 1986 to 1988, tested the feasibility of providing acute and preventive primary care for non-Medicaid indigents in local health departments. Four local departments, already providers of comprehensive preventive care, contracted with local private physicians to provide the acute care. All care was provided within health departments to ensure case management and cross-referrals to and from preventive care. Although state funding has been terminated, three of the departments continue to fund the services on their own.

Contact

C. Hemandez
Commissioner
Department for Health Services
275 East Main Street
Frankfort, Kentucky 40621
(502) 564-3970

Cross ***Reference***

Improving Access to Health Care for the Medically Indigent

Minnesota

Program

The Minnesota Department of Human Services currently is working with medical service providers in Lake County in northeastern Minnesota. The goal is to contract with Lake County providers for provision of cost-effective services to low-income county residents eligible for the state's General Assistance Medical Care program. The contract will most likely involve some risk sharing or surplus sharing between local providers and the state.

Contact

Patricia MacTaggart
Health Care Management Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155
(612) 297-4671

Cross Reference

Improving Access to Health Care for the Medically Indigent

North Carolina

Program

Carolina ACCESS is a demonstration program that uses coordinated care arrangements to improve health care for Medicaid patients. Selected counties identify or organize a network of primary care providers who agree to coordinate recipient health care services by providing or arranging primary care services, referrals for specialty services, twenty-four hour access, and assistance in providing service to participants. Managed care can improve access to quality health care for Medicaid recipients by replacing a system that encourages episodic care from a variety of providers with a program that promotes continuity of care through a primary care coordinator.

Contact

Torlen Wade
Assistant Director-Administration
Office of Rural Health and Resource Development
701 Barbour Drive
Raleigh, North Carolina 27603
(919) 733-2040

Cross Reference

Improving Access to Health Care for the Medically Indigent

PROVIDING FINANCIAL AND TECHNICAL ASSISTANCE

Financial Assistance

Arkansas

Program

In February 1989 Arkansas established the Rural Health Service Revolving Fund. These funds will be used for the support of community-based health care needs assessment, technical assistance, and long-term planning. Funding guidelines are under development.

Contact

Valetta M. Buck
Director
Health Facility Services
4815 West Markham
Little Rock, Arkansas 722053867
(501) 661-2201

California

Program

The Local Health Service Program Section uses either contracts or state staff to provide public health nursing and environmental health services to those counties with populations of under 40,000. In addition, technical assistance and consultation services are provided to counties shifting to an independent health department.

Contact

Doreen Wysocki
Chief
Local Services Section
Department of Human Service
714/744 P Street
P. 0. Box 942732
Sacramento, California 94234-7320
(916) 224-4701

Cross Reference

Improving Agricultural and Occupational and Environmental Health and Safety: Occupational and Environmental Health and Safety, Attracting Health Care Professionals: Medically Underserved Areas

California

Program

The Hospital and Medical Standards Program is responsible for identifying causes and developing solutions to problems that threaten the efficiency and survival of rural hospitals. Technical assistance and consultation is provided to rural hospitals in relation to diversification of services, swing bed designation, primary care network development, and other research and planning activities.

In addition, this program also administers the Local Health Expenditures Account, which grants funds to local health jurisdictions for capital improvement and/ or equipment purchases.

Contact

Lawrence J. McCabe Jr.
Chief, Hospital and Medical Standards Program
714 P Street, OB81 550
Sacramento, California 95814
(916) 322-4704

Cross Reference

Providing Financial and Technical Assistance: Technical Assistance

California

Program The Seasonal Agricultural Workers Health Program provides technical and financial assistance to local agencies concerned with the health of seasonal agricultural and migratory workers and their families. The program also coordinates with similar programs of the federal government and other state and voluntary agencies.

Contact

Arthur Jordan
Chief, Primary Care
Department of Health Services
714/744 P Street
P. 0. Box 942732
Sacramento, California 94234-7320
(916) 322-135.5

Cross ***Reference*** Improving Agricultural and Occupational and Environmental Health and Safety: Agricultural Safety, Providing Financial and Technical Assistance: Technical Assistance

Hawaii

Program Hawaii has taken a direct approach to state financial assistance. The state owns and manages twelve hospitals, ten of which are located in rural areas. The state legislature approves and appropriates funding for their capital improvement projects.

Contact

Marilyn Matsumaga
Special Assistant to the Deputy Director
12.50 Punchbowl Street #326
Honolulu, Hawaii 96813
(808) 548-6530

Iowa

Program In January 1989, through state legislation, the Community and Rural Development Loan Program (CORDLAP) made $3.2 million available to provide grants and low-interest loans to communities for traditional and nontraditional infrastructures.

Nontraditional infrastructures can include such health-related services as medical decision support systems and emergency medical services. The Iowa Department of Economic Development is responsible for reviewing the applications and administering the program. Applications are reviewed based on the financial need of the applicant, cost/benefit of the project, percent of matching provided, and impact of the project. Loans range from 0 to 5 percent and are awarded based on the availability of funds.

Contact

Cindy Liston
Field Representative
Iowa Department of Economic Development
200 East Grand Avenue
Des Moines, Iowa 50311
(515) 281-3752

Cross Reference Maintaining Existing Health Care Facilities

Iowa

Program The Iowa General Assembly appropriates $400,000 a year for a grant program to encourage stronger linkages with existing rural services providers and innovate economic development models. Eligible applicants include rural communities, rural counties, councils of government, and educational institutions. Health service providers may be part of the grant application team.

Contact

Kathy Beery
Rural Development Coordinator
Iowa Department of Economic Development
200 East Grand Avenue
Des Moines, Iowa 50309
(515) 281-7269

Cross Reference

Maintaining Existing Health Care Facilities

New Mexico

Program

The New Mexico Hospital Equipment Loan Council issues tax-exempt revenue bonds to generate funds from which it then issues low-interest loans and permits refinancing of previous loans.

Contact

Harvey Licht
Primary Care Section
Health and Environment Department
1190 St. Francis Drive
Sante Fe, New Mexico 87503
(505) 827-2527

New York

Program

New Yorkestablished a program that made available $1 million in each of the last three years. Funds are used to assist rural hospitals seeking to diversify and/or proposing to convert to ambulatory care or to nursing home facilities.

Contact

Dwight C. Williams
Chief Health Planner
New York State Department of Health
Bureau of Health Facility
Planning Room 1748
Albany, New York 12237
(518) 473-4705

North Carolina

Program

Operating and capital improvement assistance grants are offered by the state to assist rural health centers. In its history, $6 million has been awarded in operating grants and more than $4.5 million in capital improvement grants to rural health centers. Operating funds have assisted forty-seven rural communities and funded projects for an average of four and one-half years. Construction grants have paid for new construction or renovation in forty communities.

Contact

Jim Bernstein
Director
Office of Rural Health and Resource Development
701 Barbour Drive
Raleigh, North Carolina 27603-2008
(919) 733-2040

Oregon

Program

Senate Bill 438, passed by the 1989 Legislative Assembly, allows Type B hospitals to be treated the same as Type A hospitals and receive 100 percent of Medicaid charges instead of a smaller percentage. Type A hospitals are defined as those having fewer than fifty beds and are more than thirty miles from another acute inpatient care facility. Type B hospitals are those facilities with fewer than fifty beds and are less than thirty miles from another acute care facility.

Contact

Karen Whitaker
Office of Rural Health
Health Sciences University
3181 SW Sam Jackson Park Road, MP250
Portland, Oregon 97201-3098
(503) 2794450

South Carolina

Program

South Carolina made available $200,000 to four community health centers (CHCs) to provide support to satellite offices in existing centers in rural areas. Each CHC received $50,000.

Contact

Tom McGee
Director of Primary Care
South Carolina Department of Health
P.O. Box 8206
Columbia, South Carolina 29202-8206
(803) 737-3995

Vermont

Program

The Vermont Legislature appropriated $200,000 to the Department of Health for grants to local communities for creating innovative solutions to obstetrical shortages in rural areas of the state. Six grants were awarded to a variety of communities and services statewide. The projects were: a single point access maternity care system in the Gifford Hospital area; salary for a nurse midwife; an award to an individual to pay for nurse midwife training in exchange for one year of service; a program of Lamaze education, especially for low-income women or those on Medicaid; support for nurse midwifery, nutrition, social services, nursing, and support personnel in hospitals' prenatal care clinics; and a training program for mid-level practitioners in prenatal care.

Contact

Diane St. Claire
Health Planner
Department of Health
1193 N. Avenue
P. 0. Box 70
Burlington, Vermont 05402
(802) 863-7347

Cross Reference

Maintaining Access to Obstetrical Services

Washington

Program

The 1989 legislature established six demonstration sites for networking of providers to form an organized system of basic health services for the community. The focus of this program includes, but is not limited to, the community hospital. Six communities will receive planning funds.

Contact

Verne Gibbs
Health Planning Administration
Department of Social Health Services
Mail Stop OB-43F
Olympia, Washington 98504
(206) 753-5942

Cross *Reference*

Attracting Health Care Professionals: Recruitment and Retention

Wisconsin

Program

The Wisconsin Rural Hospital Loan Program, administered by the Division of Health, was modeled after the federal Rural Health Care Transition Grant program. The Wisconsin program offers small rural hospitals low interest loans of up to $50,000 per

year for two years. The program recently was created and is expected to award loans to as many as ten rural hospitals in spring 1990.

Contact

Richard Heinz
Department of Health and Social Services
Division of Health, Primary Care Programs
P.O. Box 1808
Madison, Wisconsin 53701-1808
(608) 267-7122

Wisconsin

Program

The Rural Economic Development Program, administered by the Department of Development, provides low-interest loans or grants to small businesses to stimulate start-up and expansion of business ventures for rural and /or small communities. Hospitals and clinics may qualify for a loan or a grant through this program.

Contact

Richard Heinz
Department of Health and Social Services
Division of Health, Primary Care Programs
P.O. Box 1808
Madison, Wisconsin 53701-1808
(608) 267-7122

Technical Assistance

California

Program

The Hospital and Medical Standards Program is responsible for identifying causes and developing solutions to problems that threaten the efficiency and survival of rural hospitals. Technical assistance and consultation is provided to rural hospitals in relation to diversification of services, swing bed designation, primary care network development, and other research and planning activities.

In addition, this program also administers the Local Health Expenditures Account, which grants funds to local health jurisdictions for capital improvement and/ or equipment purchases.

Contact

Lawrence J. McCabe Jr.
Chief
714 P Street, Room 550
Sacramento, California 95814
(916) 322-4704

Cross Reference

Providing Financial and Technical Assistance: Financial Assistance

California

Program

The Seasonal Agricultural Workers Health Program provides technical and financial assistance to local agencies concerned with the health of seasonal agricultural and migratory workers and their families. The program also coordinates with similar programs of the federal government and other state and voluntary agencies.

Contact

Arthur Jordan
Chief, Primary Care
Department of Health Services
714/744 P Street
P. 0. Box 942732
Sacramento, California 94234-7320
(916) 322-1355

Cross Reference

Providing Financial and Technical Assistance: Financial Assistance, Improving Agricultural and Occupational and Environmental Health and Safety: Agricultural Safety

Illinois

Program Because of its neutrality as an organizational unit, the Center for Rural Health can successfully advocate for rural communities to more quickly and effectively make necessary contacts. The center's involvement in the Illinois Lieutenant Governor's Rural Health Task Force and its active role in the newly formed Illinois Rural Health Association provide additional support. The center works with the Illinois Department of Commerce and Community Affairs and local community action agencies to encourage linkages with existing economic development programs.

Contact
Alvin B. Grant
Center for Rural Health
Illinois Department of Public Health
535 West Jefferson
Springfield, Illinois 62761
(217) 782-1624

Cross Reference Coordinating Activities

Indiana

Program ***The*** Indiana State Board of Health publishes the ***Indiana Health Needs Assessment by County. The*** health needs assessment is comprised of thirty-four key criteria of adequacy and 105 expanded criteria for each of Indiana's ninety-two counties. Indiana and United States data also are included for comparison purposes. These data allow each county to compare its results with those of other counties with identify potential health needs.

The Indiana State Board of Health also provides technical assistance to local health departments. The final product of the process is to establish high priority program areas among the competing priorities. About twenty-two of Indiana's ninety-six local health departments are in some phase of this process.

Contact
Keith Main
Director
Public Health Research Division
Indiana State Board of Health
1330 West Michigan Street
P.O. Box 1964
Indianapolis, Indiana 46206-1964
(317) 6338521

Iowa

Program In an effort to prevent farm-related injuries Iowa has established a community-based family risk assessment and education program. This campaign, targeted to farm youth, is accomplished through a farm family safety survey and community involvement workshops, and is publicized through radio and television. In addition, a farm family safety walkabout training program is conducted with information and materials to perform a safety walkabout on individual family farms. Participants learn to recognize existing farm hazards and receive assistance in changing the farm workplace into a safe environment.

Contact
Roger Chapman
Program Manager
Disability Prevention Program
Iowa Department of Public Health
Des Moines, Iowa 50311
(515) 281-6646

Cross ***Reference*** Improving Agricultural and Occupational and Environmental Health and Safety: Agricultural Safety

Iowa

Program

WORKSAFE Iowa established an Occupational Medicine and Associate program with the goal of promoting occupational health and safety through education and consultation. The program was designed to assist community hospitals in implementing and strengthening their occupational medicine clinics and related outreach services. In addition, the community hospitals serve as vehicles to integrate WORKSAFE Iowa services into local communities. The program began in fall 1988 with a competitive bid. Five hospitals were selected and each was asked to contribute a membership fee.

Contact

James A. Merchant or Loii Albrecht
The University of Iowa
Institute of Agricultural Medicine and Occupational Health
Department of Preventive Medicine and Environmental Health
College of Medicine, Oakdale Campus
Iowa City, Iowa 52242
(319) 335441.5

Cross Reference

Improving Agricultural and Occupational and Environmental Health and Safety: Agricultural Safety

Iowa

Program

In 1987 the Iowa Legislature appropriated $60,000 per year for a two-year period to develop a model agricultural health and safety prevention program. The Iowa Agricultural Health and Safety Service Pilot Project (IA-HASSPP) is modeled after the Swediih program, Lantbrukshalsan, which is the first in the world to provide comprehensive occupational health and prevention services specifically to farmersand farm families. The main objectives of IA-HASSP include accessible occupational health and safety services, program evaluation for cost-effectiveness, and public acceptance.

IA-HASSP program components include health education, physical exams, screening for pesticide, noise and other overexposures, and industrial hygiene and safety services, including on site farm walk-through and fitting for personal safety equipment. Statewide, the IA-HASSP hospital-based program is coordinated by the Institute of, Agricultural Medicine and Environmental Health at the University of Iowa. Grants to hospitals are administered through the Office of Rural Health, Iowa Department of Public Health.

Contact

Gerd Clabaugh
Administrator
Office of Health Planning
Iowa Department of Public Health
Locus State Office Building
Des Moines, Iowa 50319
(515) 281-4346

Cross *Reference*

Improving Agricultural and Occupational and Environmental Health and Safety: Agricultural Safety

Nebraska

Program

The Nebraska Capacity Building Project in occupational safety and health is a five-year project currently in its third year. The objectives of the project include establishing surveillance of farm worker exposures to pesticides by using case data collected in 1986 and providing technical assistance to the public concerning pesticide exposure.

Contact

Adi Pour
Department of Health
301 Centennial Mall South
P. 0. Box 95007
Lincoln, Nebraska 68509-5007
(402) 471-2541

Cross Reference Improving Agricultural and Occupational and Environmental Health and Safety: Agricultural Safety

North Carolina

Program In 1985 North Carolina established the Community Hospital Technical Assistance Program to provide technical assistance to small community hospitals. More than forty hospitals have requested and received assistance. Through this program, staff assist hospitals in long-range planning, conduct analysis, coordinate programs with state and federal agencies, provide architectural and design assistance, and examine alternative revenue sources for the hospitals. Consultants are hired by the office when specialized assistance is required.

Contact
Torlen L. Wade
Assistant Director - Administration
Office of Rural Health and Resource Development
701 Barbour Drive
Raleigh, North Carolina 27683
(919) 733-2040

North Carolina

Program The North Carolina Office of Rural Health and Resource Development offers on-site specialized technical assistance to rural hospitals. Assistance is available in the areas of management review, market analysis, feasibility analysis, and scheduling and patient flow. In addition, the office provides training to members of the governing boards of the rural health centers on topics ranging from federal health policy to the legal responsibilities of board members.

Contact
Torlen L. Wade
Assistant Director -Administration
Office of Rural Health and Resource Development
701 Barbour Drive
Raleigh, North Carolina 27603
(919) 733-2040

North Carolina

Program The Maternal and Child Health Project assists twenty-two primary care centers in providing intensive perinatal services. The maternity consultants have developed and implemented manual and computerized management information systems in each center. In addition, assistance includes community organizing, program development and consulting, information systems development, grant writing, and publications.

Contact
Ann Wolfe
Division of Maternal and Child Health
701 Barbour Drive
Raleigh, North Carolina 27603
(919) 733-3816

Cross Reference Maintaining Access to Obstetrical Services

New York

Program The Hospital Voluntary Assessment Tool was developed by the Rural Health Council of New York State to assist rural hospitals in self-evaluation and planning. The tool is strictly voluntary, and the information collected may be shared with any public agency at the discretion of participating hospitals.

Contact

Paul FitzPatrick
Rural Health Council
New York State Department of Health
Albany, New York
(518) 474-5665

Oklahoma

Program

Health Planning Services developed computer software that generates a "Trend Analysis Management and Marketing Profile" for the previous six years of a hospital's operation. About fifty hospitals have received this profile during the past year.

Contact

Alan Grubb
Chief of Health Planning Services
Oklahoma Department of Health
P.O. Box 5355 1
Oklahoma City, Oklahoma 73152
(405) 27 l-6073

Oregon

Program

Senate Bill 438 appropriates $100,000 for the biennium ending June 30, 1991, for the Office of Rural Health to contract for professional services to recruit physicians to practice in rural areas and provide technical assistance in restructuring rural health services.

Contact

Karen Whitaker
Office of Rural Health
Health Sciences University
3181 SW Sam Jackson Park Road, MP250
Portland, Oregon 972013098
(503) 279-4450

Cross ***Reference***

Providing Financial and Technical Assistance: Financial Assistance, Attracting Health Care Professionals: Recruitment and Retention

Oregon

Program

Since its creation in 1979, the Office of Rural Health has played a major role in the promotion of rural health issues. The office provides guidance to rural communities regarding community organization and clinic development; conducts ongoing primary care planning for underserved areas on a statewide basis; assists rural communities in the recruitment and retention of health care providers; provides data and assistance in the development of formally designated Health Manpower Shortage Areas, Medically Underserved Areas, and High Migrant Impact Areas; serves as the central agency for coordination of statewide efforts for the delivery of health care to rural areas; provides assistance to rural clinics with recruitment and retention of health care providers; and provides technical assistance to rural hospital administrators and boards of directors to identify strengths and weaknesses and assess opportunities for development.

Contact

Karen Whitaker
Office of Rural Health
Health Sciences University
3181 SW Sam Jackson Park Road, MP250
Portland, Oregon 97201-3098
(503)279-4450

Cross Reference

Coordinating Activities, Attracting Health Care Professionals: Recruitment and Retention

South Dakota

Program The Office of Rural Health Administration designed a program to evaluate the problems facing rural hospitals and suggest ways to solve them. Approximately forty hospitals participated during the past year.

Contact
Bernie Osberg
Manager
South Dakota Office of Rural Health
Pierre Office
Pierre, South Dakota 5X01-3182
(605) 773-3693

Utah

Program *The* Bureau of focal and Rural Health Systems provides assistance in identifying funding sources, grantsmanship, studies on rural hospital issues, and resolving problems.

Contact
Robert Sherwood
Director
Bureau of Local and Rural Health Systems
288 North 1460 West
P.O. Box 16660
Salt Lake City, Utah 84116-0660
(801) 5386113

West Virginia

Program A task force has worked with two rural hospitals on changing their missions from acute care institutions to more comprehensive rural health centers.

Contact
David K. Heydinger
Director
West Virginia Department of Health
1800 Washington Street, East
Charleston, West Virginia 25305
(304) 348-2771

Cross Reference Maintaining Existing Health Care Facilities

IMPROVING AGRICULTURAL AND OCCUPATIONAL AND ENVIRONMENTAL HEALTH AND SAFETY

Agricultural Safety

California

Program The Seasonal Agricultural Workers Health Program provides technical and financial assistance to local agencies concerned with the health of seasonal agricultural and migratory workers and their families. The program also coordinates with similar programs of the federal government and other state and voluntary agencies.

Contact

Arthur Jordan
Chief
Primary Care Department of Health Services
714/744 P Street
P. 0. Box 942732
Sacramento, California 94234.7320
(916) 322-1355

Cross Reference

Providing Financial and Technical Assistance

Iowa

Program

In an effort to prevent farm-related injuries Iowa has established a family risk assessment and education program. This campaign, targeted at farm youth, is accomplished through a farm family safety survey and community involvement workshops, and is publicized through radio and television. In addition, a farm family safety walkabout training program will be conducted, with information and materials to perform a safety walkabout on individual family farms. Participants learn to recognize existing farm hazards and receive assistance in changing the farm workplace into a safe environment.

Contact

Roger Chapman
Program Manager
Disability Prevention Program
Iowa Department of Public Health
Des Moines, Iowa 50311
(515) 281-6646

Cross *Reference*

Providing Financial and Technical Assistance: Technical Assistance

Iowa

Program

In 1987 the Iowa Legislature appropriated $60,000 per year for a two-year period to develop a model agricultural health and safety prevention program. The Iowa Agricultural Health and Safety Service Pilot Project (IA-HASSPP) is modeled after the Swedish program, Lantbrukshalsan, which is the first in the world to provide comprehensive occupational health and prevention services specifically to the farmer and farm families. The main objectives of the IA-HASSP include accessible occupational health and safety services, program evaluation for cost-effectiveness, and public acceptance. IA-HASSP is a hospital-based program of health and safety services for agricultural workers and their families.

IA-HASSP program components provided to enrollees by participant hospitals include: health education, physical exams, screening for pesticide, noise, and other overexposures, and industrial hygiene and safety services, including on-site farm walkthroughs and fitting for personal safety equipment. Statewide, the IA-HASSP hospital-based program is coordinated by the Institute of Agricultural Medicine and Environmental Health at the University of Iowa. Grants to hospitals are administered through the Office of Rural Health, Iowa Department of Public Health.

Contact

Gerd Clabaugh
Administrator
Office of Health Planning
Iowa Department of Public Health
Locus State Office Building
Des Moines, Iowa 50319
(515) 281-4346

Cross *Reference*

Providing Financial and Technical Assistance: Technical Assistance

Kansas

Program

In 1985 the Kansas Legislature established the Farmer's Assistance Counseling and Training Service (FACTS). FACTS is a hotline that assist farmers, ranchers, agribusinessmen, and their families in avoiding or alleviating the problems and stress

resulting from the agricultural crisis in rural areas. The hotline is a no-cost service offering counseling, assistance, and referrals by professionally qualified specialists. The project is a joint effort between the Kansas State Board of Agriculture and the Kansas Cooperative Extension Service.

Contact

Char Henton
9 Leisure Hall
Kansas State University
Manhattan, Kansas 66506-3504
(913) 532-6958

Cross Reference

Improving Access to Mental Health, Alcohol, and Substance Abuse Treatment

Texas

Program

Two programs addressing rural health issues are run through the General Sanitation Division of the Texas Department of Health. The Migrant Labor Housing Sanitation Program is responsible for the licensing and inspection of housing provided to migrant, seasonal, or temporary agricultural workers and for housing inspections for the U.S. Department of Labor's Alien Certification and Temporary Agricultural Worker (H2-A) Programs. The Field Sanitation Program is responsible for ensuring employer compliance with the state's field sanitation standards. These standards require employerswith workers at a temporary job site to furnish them potable drinking water, toilet facilities, and handwashing facilities, along with other amenities.

Contact

Elias Briseno
Chief
Migrant Labor Housing and Field Sanitation Branch
General Sanitation Division
(512) 458-7521, ext. 6607

Occupational and Environmental Health and Safety

California

Program

The Local Health Service Program Section uses either contract funds or state staff to provide public health nursing and environmental health services to those counties with a population of less than 40,000. In addition, technical assistance and consultation is provided to those counties transitioning to an independent health department.

Contact

Doreen Wysocki
Chief
Local Services Section
Department of Health Services
714/744 P Street
P. 0. Box 942732
Sacramento, California 94234-7320
(916) 224-4701

Cross Reference

Providing Financial and Technical Assistance: Financial Assistance, Attracting Health Care Professionals: Medically Underserved Areas

Iowa

Program

WORKSAFE Iowa established an Occupational Medicine and Associate program with the goal of promoting occupational health and safety through education and consultation. The program was designed to assist community hospitals in implementing and strengthening their occupational medicine clinics and related outreach services. In addition, the community hospitals serve as a vehicle to integrate WORKSAFE Iowa services into local communities. The program began in fall 1988with a competitive bid. Five hospitals were selected and each was asked to contribute a membership fee.

Contact

James A. Merchant or Loii Albrecht
The University of Iowa
Institute of Agricultural Medicine and Occupational Health
Department of Preventive Medicine and Environmental Health
College of Medicine, Oakdale Campus
Iowa City, Iowa 52242
(319) 3354415

Cross Reference

Providing Financial and Technical Assistance: Technical Assistance

Nebraska

Program

The Nebraska Capacity Building Project in Occupational Safety and Health is a five-year project currently in its third year. The objectives of the project include establishing surveillance of farm worker exposures to pesticides by using case data collected in 1986 and providing technical assistance to the public concerning pesticide exposure.

Contact

Adi Pour
Department of Health
301 Centennial Mall South
P. 0. Box 95007
Lincoln, Nebraska 68509-5007
(402) 471-2541

Cross Reference

Providing Financial and Technical Assistance: Technical Assistance

South Dakota

Program

A state law passed in 1990 requires the Department of Health to collect data on farming and agricultural injuries. Thii legislation will help define the extent of the problem in the state and may lead to additional programs directed toward improving occupational and environmental health and safety, especially in rural areas.

Contact

Bernie Osberg
Manager
Office of Rural Health
523 East Capitol Avenue
Pierre, South Dakota 51501
(685) 773-3361

Texas

Program

In 1987 the Texas Legislature passed the Agricultural Hazard Communication Act (Right to Know). The purpose of this law is to give farmworkers access to information about pesticide used on Texas crops, their health effects, and ways to reduce pesticide risks to farm workers and their families. Employers covered by this law are those who use, store, purchase or have caused to be used more than the threshold amount of any one covered chemical; and who hire agricultural laborers and pay them more than the "payroll thresholds," defined as $15,000 or more annual payroll expenses plus labor for agricultural workers for seasonal or migrant work or $50,000 or more annual payroll expenses for agricultural workers for year-round employment.

Contact

Right to Know Program
Department of Agriculture
P.O. Box 12847
Austin, Texas 78711
(512) 463-7542

COORDINATING ACTIVITIES

Illinois

Program Because of its neutrality as an organizational unit, the Center for Rural Health can successfully advocate for rural communities. Effectively networking with other state agencies and organizations allows local communities to more quickly and effectively make necessary contacts. The center's involvement in the Illinois Lieutenant Governor's Rural Health Task Force and its active role in the newly formed Illinois Rural Health Association provide additional support. The center works with the Illinois Department of Commerce and Community Affairs and local community action agencies to encourage linkages with existing economic development programs.

Contact
Alvin B. Grant
Center for Rural Health
Illinois Department of Public Health
535 West Jefferson
Springfield, Illinois 62761
(217) 782-1624

Cross Reference Providing Financial and Technical Assistance: Technical Assistance

Kansas

Program The Kansas Senior Care Act is a special project to provide personal care and homemaking services to persons sixty years or older residing in rural northeast Kansas. Persons eligible are those residents of Brown, Nemaha, Jackson, and Doniphan counties. The program is jointly funded by the Kansas Department on Aging and the Community Program for Accessible Health Care.

Contact
Bill Cutler
Department of Health Environment
London State Office Building
Topeka, Kansas 66612-1290
(913) 296-4986

Kentucky

Program The Kentucky Physician Placement Service, an agency of the Department for Health Services, recruits primary care physicians for placement in predominantly rural, medically underserved counties. Recruitment is on behalf of community requests, mainly from local hospital administrators and physicians. There is no charge to either party for this service.

Contact
Don Coffey
Manager
Community Health Development Branch
Department for Health Services
275 East Main Street
Frankfort, Kentucky 40621
(502) 564-3386

Cross ***Reference*** Attracting Health Care Professionals: Medically Underserved Areas, Attracting Health Care Professionals: Recruitment and Retention

Maine

Program *The* Maine Cooperative Agreement for Primary Care Services was first implemented on October 1, 1985. The cooperative agreement is a three-way agreement among the federal government, the state's primary care association, and the state of Maine. Its

focus is to coordinate federal and state primary care resources; help medically underserved populations and health care providers recruit and retain physicians and other health professionals; promote the use of state primary care resources; and promote affiliations and coordination with area health providers and the state's health department, area health education center, hospitals, and residency programs. In addition, the cooperative agreement maintains an active clearinghouse of site vacancies and health care provider files.

Contact

Sophie Glidden
Rural Health Program Manager
Department of Human Services
Augusta, Maine 04333
(207) 289-2716

Cross Reference

Attracting Health Care Professionals: Recruitment and Retention, Attracting Health Care Professionals: Medically Underserved Areas

Minnesota

Program

The Minnesota Department of Health's Emergency Medical Services program credentials EMTs and paramedics and oversees the operation of EMS systems throughout the state. The program currently is working on legislative proposals to increase the supply of EMTs and to provide other incentives to foster recruitment and retention of EMS personnel.

Contact

Norm Hanson
Chief
Minnesota Department of Health
Central Medical Building
393 North Dunlap Street
St. Paul, Minnesota 55164
(612) 643-2164

Cross ***Reference***

Improving Emergency Medical Care

Nebraska

Program

The Office of Rural Health provides consultation on a limited basis to rural communities in the areas of local planning, resource development, and physician recruitment and retention. Pilot projects in two multi-county areas have been implemented to measure use of and satisfaction with the local health care systems and the development of local health resources.

Contact

David Palm
Director
Office of Rural Health
Nebraska Department of Health
P.O. Box 95007
Lincoln, Nebraska 68509
(402) 471-2337

North Dakota

Program

Governor Sinner issued an executive order creating the Policy and Planning Commission for Alcohol and Other Drug Abuse Prevention. The commission consists of representatives of state agencies involved in prevention efforts, two state legislators, a representative of the Governor's office, and two citizens-at-large. Its mission is to develop a comprehensive plan to coordinate efforts and to reduce duplication and gaps in programs and services to the state.

Contact

John Allen
Director
Division of Alcoholism and Drug Abuse
Department of Human Services
Bismark, North Dakota 58.505
(701) 224-2769

Oregon

Program

Since its creation in 1979, the Office of Rural Health has played a major role in the promotion of rural health issues. The Office of Rural Health provides guidance to rural communities regarding community organization and clinic development; conducts ongoing primary care planning for underserved areas on a statewide basis; assists rural communities in the recruitment and retention of health care providers; provides data and assists in the development of formally designated Health Manpower Shortage Areas, Medically Underserved Areas, and High Migrant Impact Areas; serves as the central agency for coordination of statewide efforts for the delivery of health care to rural areas; provides assistance to rural clinics with recruitment and retention of health care providers; and provides technical assistance to rural hospital administrators and boards of directors to identify strengths and weaknesses and assess opportunities for development.

Contact

Karen Whitaker
Office of Rural Health
Health Sciences University
3181 SW Sam Jackson Park Road, MP250
Portland, Oregon 97201-3098

Cross Reference

Providing Financial and Technical Assistance: Technical Assistance, Attracting Health Care Professionals: Recruitment and Retention

Pennsylvania

Program

The ROOTS Program (Rural Opportunities Offer Tomorrow's Success), developed by the Center for Rural Pennsylvania, is a comprehensive package of critical legislative and executive initiatives that would build a better future for rural Pennsylvania. These programs are designed to address several problems by creating a better educated rural workforce; helping rural areas benefit from urban growth; ensuring rural areas do not lose critical community hospitals; and increasing access to a wide range of state programs.

Contact

Emily Gruss
Associate Director
Center for Rural Pennsylvania
Suite 408
212 Locust Street
Harrisburg, Pennsylvania 17101
(717) 787-9555

South Dakota

Program

The South Dakota Office of Rural Health provides technical assistance to rural communities to assist them in developing rural resources that match the needs of people in their service areas. Technical assistance is provided in these areas: comprehensive community assessments, recruitment and retention of primary health care personnel, community involvement/empowerment, provision of health care data and information, rural hospital assistance, and assistance in the development of rural health clinics.

Contact

Bernie Osberg
Manager
Office Rural Health
523 Capitol Avenue
Pierre, South Dakota 57501
(605) 773-3361

Texas

Program

The Center for Rural Health Initiatives was established by the Texas Legislature in 1989. The purpose of the center is to assume a leadership role in working or contracting with state and federal agencies, universities, private interest groups, communities, foundations, and offices of rural health to develop rural health initiatives and maximize the use of existing resources without duplicating existing effort. In addition, the center serves as a central information and referral source and as the primary state resource in coordinating, planning, and advocating continued access to rural health care services in Texas.

Contact

Bryan Sperry
Executive Director
Commission for Professional Services
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199
(512) 458-7111

Washington

Program

The Grays Harbor Community Chronic Disease Planning Project is forming a community coalition that will prioritize chronic disease problems and develop chronic disease interventions tailored to the community. The project builds the capacity within the rural setting to confront future health issues as they arise. The coalition is composed of members of various community health agencies, local physicians, hospitals, schools, and minority groups.

Contact

Kim Ambungy
Health Promotion and Chronic Disease Prevention
Mail Stop: LK-13
Olympia, Washington 98504
(206)753-7520

Appendix
State Rural Health Contacts

ALABAMA

Frank Williford
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Department of Family and Community Medicine
University of Arizona
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(602) 626-6429 (FAX)

ARKANSAS

Yvette Lamb
Director
Office of Primary Care
Arkansas Department of Health
4815 West Markham Street, SLOT #22
Little Rock, Arkansas 72205
(501) 661-2194
(501) 661-2468 (FAX)

CALIFORNIA

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Chief
Rural and Community Health Division
Department of Health Services
California Department of Health
714 P Street, Room 540
Sacramento, California 95814
(916) 322-2078
(916) 324-4208 (FAX)

GEORGIA

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Director
Office of Rural Health
Division of Public Health
Georgia Department of Human Resources
878 Peachtree Street, Northeast
Suite 100
Atlanta, Georgia 30309-9844
(404) 894-4283
(404) 894-7799 (FAX)

IDAHO

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Idaho Rural Health Education Center
Mountain States Health Corporation
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Boise, Idaho 83707
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ILLINOIS

Alvin Grant
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Center for Rural Health
Illinois Department of Public Health
535 West Jefferson
Springfield, Illinois 62761
(217) 782-4977
(217) 782-3987 (FAX)

IOWA

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Administrator
Office of Rural Health
Iowa Department of Public Health
Lucas State Office Building
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KANSAS

Steve McDowell
Director
Office of Rural Health
Kansas Department of Health and Environment
Landon State Office Building
9th and Jackson
Topeka, Kansas 66612-I 290
(913) 296-6752
(913) 296-6231 (FAX)

MISSISSIPPI

Harold Armstrong
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Division of Health Planning and Resource Development
Department of Health
P.O. Box 170012423
North State Street
Jackson, Mississippi 39215-l 700
(601) 960-7874
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MONTANA

Frank Newman
Director
Area Health Education Center
Montana State University
308 Culberston Hall
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Office of Rural Health
Division of Health Policy and Planning
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NEW MEXICO

Harvey Licht
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Health and Environment Department
1190 St. Francis Drive
Sante Fe, New Mexico 87503
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NORTH CAROLINA

Jim Bernstein
Director
Office of Rural Health and Resource Development
311 Ashe Avenue
Raleigh, North Carolina 27606
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(919) 733-8300 (FAX)

NORTH DAKOTA

Jack Geller
Director
Center for Rural Health
School of Medicine
University of North Dakota
501 Columbia Road
Grand Forks, North Dakota 58203
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(701) 777-2389 (FAX)

OREGON

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Office of Rural Health
Oregon Health Sciences University
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Portland, Oregon 97201-3098
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Office of Rural Health
800 East 21st Street
Sioux Falls, South Dakota 57117-5045
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Austin, Texas 78756
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